SUMMARY PLAN DESCRIPTION
FOR EMPLOYEES
OF
UNIVERSITIES RESEARCH ASSOCIATION, INC.
FERMI NATIONAL ACCELERATOR LABORATORY

Universities Research Association, Inc.
under contract with the United States Department of Energy
operates Fermi National Accelerator Laboratory

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POLICY STATEMENT

One of the major policies of Universities Research Association, Inc. (Fermi National Accelerator Laboratory) is to provide a comprehensive program of benefits for its employees. A great deal of effort is expended to provide you with a program to enhance your welfare as a URA/Fermilab employee. The majority of the program costs are borne by URA/Fermilab. Your share of the costs is identified in each plan's summary plan description.

The plans described herein include life, medical, dental, disability, flexible benefits, business travel accident, severance and voluntary supplemental pension benefits. The basic pension plan and the long-term care insurance plan are not included. Separate summary plan descriptions are provided to participants when they become eligible to enroll in those plans.

Every effort has been made to make the summary plan descriptions as accurate as possible. However, they are only a simplified explanation of the principal features of the plans; your benefit rights are described in more detail in each separate plan document. The provisions of each plan document control in all circumstances: even if they appear inconsistent with any of the descriptions contained herein. Nothing herein should be deemed to waive or alter any of the terms or conditions of the policies of insurance covering the insured benefit plans, the annuity contracts and HMO contracts. The benefits and other principle provisions are effective only if you are eligible to participate, become a participant, and remain a participant in accordance with the provisions of the plans.

You may examine copies of the Plan Document and related legal documents without charge and obtain copies of them. Contact the sponsor to examine or obtain copies.

It is the intent of URA/Fermilab to continue to provide the benefit plans described in the summary plan descriptions. However, they reserve the right to amend, modify or terminate any or all of the plans at any time in their sole discretion.

No person has the authority to make any verbal statement of any kind at any time which is legally binding upon URA/Fermilab.

The information herein does not constitute a contract of employment.

Flexible Benefits Plan

Administered by
Connecticut General Life Insurance Company (CIGNA)

INTRODUCTION

The URA/Fermilab Flexible Benefits Plan ("Plan") has been adopted effective January 1, 1993. This booklet represents general information only regarding the terms of the plan.

To help you identify the plan and who to contact when you have questions about the plan, please refer to the following information:

Name of Plan
URA/Fermilab Flexible Benefits Plan

Plan Number
514

Type of Plan
Welfare benefit plan offering health benefits, and medical expense and dependent care reimbursement through a "cafeteria plan" format under Section 125 of the Internal Revenue Code

Plan Year
Calendar Year

Plan Sponsor, Plan Administrator and Agent for Service of Legal Process
Universities Research Association, Inc.
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, IL 60510-0500
630-840-3396
Attn: Head, Laboratory Services Section

Employer I.D. Number of Plan Sponsor:
52-0816670

Third Party Administrator:
CIGNA Reimbursement Accounts
P.O. Box 0976
Bristol, CT 06010

OVERVIEW OF THE PLAN

Purpose of Plan
The purpose of the Plan is to offer you the opportunity to have a portion of your compensation from the Sponsor applied toward obtaining various health benefits, dependent care assistance benefits and various insurance benefits for you and your dependents on a before-tax basis. By applying a portion of your compensation in this manner, your taxable income generally is lower. Therefore, your federal and state income taxes and FICA (Social Security) taxes in most cases will be lower. This means more money for you to spend.

Because the income tax laws change frequently, and may affect different individuals in different ways, we cannot assure you that it will be to every employee's advantage to choose to pay for every benefit offered under the Plan on a before-tax basis. Having that choice through the Plan, however, will ensure that you have every opportunity to obtain your share of benefits from the Sponsor by the least expensive means presently available under the law.

Benefits Offered
The Plan permits you to elect to apply a portion of your compensation toward any of the following benefits:

1. Your share of any of the medical and dental insurance premiums for URA/Fermilab sponsored welfare plans; and
2. Unreimbursed health care expenses for treatment of yourself or your family members; and
3. Dependent Care expenses.

The benefits available to be paid for through the Plan are more fully explained later in this booklet.

Irrevocability of Elections
In general, any election you make relating to benefits under the Plan for any plan year must remain in effect throughout that plan year. In other words, once an election becomes effective for any plan year, that election generally cannot be changed or revoked until the next plan year. However, there are important exceptions to this general rule. Under these exceptions, you may change or revoke your election during the plan year if you (i) incur a change in family status during the plan year, (ii) terminate

employment during the plan year, or (iii) suffer a large increase or decrease (20% or more) in the cost or level of benefits of the health insurance plans that you elected. The Plan's election procedures, and the meaning of a change in family status, are explained in greater detail in the section "Changing Your Elections."

ELIGIBILITY

Every individual who is employed by the Sponsor and who is eligible to participate in the group medical and dental programs that the Sponsor maintains under its personnel policies and procedures is eligible. An eligible employee is not required to participate in the Plan. For any plan year, an eligible employee may choose to participate in the Plan with respect to any or all of the benefits offered for which that employee is eligible according to the terms of (i) the applicable medical and dental plans or (ii) the Health Care Reimbursement Plan or Dependent Care Reimbursement Plan.

BENEFITS AVAILABLE

Options

1. Insurance Premium Benefits

The Sponsor maintains plans for providing employees and their families with certain welfare benefits such as medical and dental coverage. These benefits may be provided under various insurance plans. The Plan enables you to participate in any one or more of these insurance programs and to pay the premiums more cheaply by using before-tax dollars.

You have received a written booklet or certificate explaining your benefit rights under those benefit plans in which you are eligible to participate.

2. Health Care Reimbursement Plan

Some medical and dental expenses incurred by you and your enrolled family members will not be covered by your group health plan. For example, deductible and co-payment amounts come out of your pocket, as do expenses in excess of reasonable and customary coverage limits and expenses for certain medical and dental procedures or treatments that are excluded from coverage under the health plan. The Plan offers you an opportunity to pay those expenses more cheaply with before-tax dollars. You may elect to have up to $2,000.00 withheld each plan year from your compensation and credited to your Health Care Reimbursement Account to be used to pay uninsured medical and dental expenses for you or your family members. A sample list of these expenses is included at the end of this booklet. Premiums for your health plan coverage may not be paid out of your Health Care Reimbursement Account.

3. Dependent Care Reimbursement Plan

Amounts may be deposited into your Dependent Care Reimbursement Account to reimburse you for dependent care expenses such as child care centers, family day care providers, nursery school, baby sitters, and caregivers for disabled dependents. Your dependent must be either (a) under age 13 and eligible to be claimed as an exemption on your federal income tax return or (b) a spouse or other dependent who is physically or mentally incapable of caring for themselves. Your spouse must work, be looking for work, or attending school full-time. The Plan offers you the opportunity to pay these expenses with pre-tax dollars. You may elect to have up to $5,000.00 ($2,500.00 if you are married but file your income tax return as a single individual) withheld each plan year for this purpose.

One of the advantages of the Plan is that it offers employees choices, so they have the opportunity to elect what is best for their individual circumstances. To make these choices concerning your benefits, you need to consider your personal circumstances carefully. Neither the Sponsor nor the Administrator can give personal tax or financial planning advice, so you may want to consult with your own adviser before making benefit elections under the Plan.

Your Benefit Accounts

You will have the opportunity to elect what amount of your compensation, if any, you wish to contribute towards any of the benefits for which you are eligible that are offered under the Plan. Your elections must be made on an enrollment form available from the Fermilab Employee Benefits Office.

An account will be established in your name under the Plan for each of the benefits you elect to contribute to. These accounts include the following:

1. a "Health Care Reimbursement Account" for paying uninsured medical and dental expenses for you and your family;

2. a "Dependent Care Reimbursement Account" for paying your dependent care expenses;
3. your contributions for your share of insurance premiums will automatically be deducted from your paycheck on a before-tax basis. If you do not want to pay your insurance premiums on a before-tax basis you must sign a waiver form.

Your premium deductions must equal your share of the full premium cost for whichever medical and dental coverage(s) you select. If premium rates change mid-year, then your contribution (hence, withholdings from your future paychecks) will automatically be adjusted.

Amounts will be withheld from your paychecks in accordance with your election and credited to your Health Care Reimbursement Account and Dependent Care Reimbursement Account. Your Accounts will be charged as you submit claims for payment. (Claim payment procedures are discussed in section "Payment of Claims.")

Your claims must be documented by submitting an acceptable description of the health expense and the amount of it from an independent third party (such as a detailed bill from the service provider). You must also submit a written statement that any medical or dependent care expense claim (or any designated part of it) is not covered by your health insurance and that you have not been reimbursed for that expense. If you submit a proper claim for health reimbursement that exceeds the amount contributed to your Health Care Reimbursement Account to that date, that claim will still be paid up to the total amount you elected to contribute to that Account for the whole year reduced for any prior reimbursements.

Your Accounts do not earn interest during the year. They are simply bookkeeping records to keep track of how much has been withheld from your paychecks under the Plan and how much is available to pay for each of your elected benefits.

Unused Amounts

The total amount of funds, if any, remaining in the Health Care Reimbursement Accounts of all participants after the payment of all claims reimbursements and administrative expenses of the Accounts shall be forfeited. The total amount of funds, if any, remaining in the Dependent Care Reimbursement Accounts of all participants after the payment of all claims reimbursements and administrative expenses of the Accounts shall be forfeited.

PARTICIPATION PROCEDURES

Voluntary Participation

Participation in the Plan is completely voluntary. If you are eligible to participate, you may complete an enrollment form available from the Fermilab Employee Benefits Office. If you choose to participate in the Plan, you may designate on the enrollment form which of the benefits offered under the Plan you wish to pay your share of the cost of on a before-tax basis.

You may not elect any benefit for which you are not eligible under the terms of the insurance policy governing that benefit. The Plan simply offers you the opportunity to pay your share of the cost of particular benefits on a generally favorable before-tax basis. It does not alter the conditions for being eligible for the particular benefits offered under the Plan, so it is possible that some eligible employees may not be eligible for all of the benefits offered under the Plan.

Annual Elections

Participation is elected on the basis of the "plan year." Each plan year runs for 12 months. The calendar year is the plan year.

If you are already eligible before the start of a plan year, you should complete and file your enrollment form for that plan year with the Sponsor during the open enrollment period scheduled before the start of the plan year.

IF YOU FAIL TO MAKE AN ANNUAL ELECTION, YOU WILL BE DEEMED TO HAVE MADE AN ELECTION NOT TO PARTICIPATE IN THE HEALTH CARE REIMBURSEMENT AND DEPENDENT CARE REIMBURSEMENT PLANS FOR THE FOLLOWING PLAN YEAR.

If you fail to waive out of the Premium Conversion portion of the Plan, you will be deemed to have made an election to have your health and dental care premiums paid on a before-tax basis. Your application then will be effective for that entire plan year.

If you first become eligible to participate in the Plan in the middle of a plan year, you may elect to participate for

the remainder of that plan year by filing an enrollment form within thirty (30) days after your first day of employment. Your participation will begin on the start of the first payroll period beginning after your application is filed.

Changing Your Elections

Once you make an application for a plan year, the elections on that application cannot be changed or revoked during that year unless you have a change in status. A change in status includes:

- your marriage, divorce, legal separation or annulment;
- the death of your spouse or dependent;
- the birth, adoption or placement for adoption of a dependent;
- the start or loss of your employment, your spouse or dependent;
- a change in work schedule, including an increase or decrease in the number of hours of employment by the employee, spouse or dependent, including a switch between full-time and part-time status, a strike or lockout and commencement or return from an unpaid leave of absence;
- a dependent satisfies or ceases to satisfy the requirements for unmarried dependents;
- a change in the place of residence or work site of the employee, spouse or dependent; and
- a significant change in the health coverage available through your spouse's employment.

If a change in status occurs, you may change your elections under the Plan for the remainder of the plan year. However, any such changes must be caused by and consistent with the change in status that occurred.

If you terminate employment during a particular plan year you will be permitted, but not required, to revoke your elections for the remainder of that plan year. However, if you revoke your election and return to employment during that plan year, you may not make a new election.

In addition, if a change in status occurs that entitles an employee, or family member to COBRA continuation of coverage (or coverage under a similar state program) COBRA premiums can be paid on a before tax basis through payroll deductions.

Compensation Reductions

Your share of the cost of whatever benefits you designate on your application form will be withheld from your paycheck for the portion of the plan year to which your application applies.

If you receive reimbursement under the Dependent Care Assistance Plan, you cannot take advantage of the dependent care tax credit for those expenses. You should consult with your tax advisor to determine whether you save more money by taking the tax credit or by participating in the Dependent Care Assistance Plan.

Payment of Claims

The Sponsor or its delegate will provide you with the necessary forms for submitting claims for reimbursement under your Health Care Reimbursement Account and Dependent Care Reimbursement Account. Claims on the appropriate forms (with acceptable documentation of the claims) which are submitted will be paid in a minimum amount of $50.00 as soon as practicable after receipt by the Sponsor or its delegate in accordance with the terms of the Plan. All claims for a plan year must be submitted no later than ninety (90) days after the end of the plan year; provided, however, if you terminate employment during the plan year, you will have until the end of the next fiscal quarter to submit your claims for expenses you incurred prior to your termination of employment. Payment is made to you and not the service provider.

If you believe that you are entitled to a greater benefit than that determined by the Sponsor or its delegate, you may file a claim in writing with the Sponsor or its delegate. The Sponsor through its delegate must, within 90 days after the receipt of the claim, either allow or deny the claim in writing. The denial must include:

1. The specific reason for the denial and reference to pertinent Plan provisions; and
2. A description of any additional material or information necessary for you to perfect your claim, the reasons such material or information is needed, and an explanation of the Plan's claim procedure.

If your claim is denied, you or your authorized representative may, within 60 days after the receipt of the denial, write the Sponsor or its delegate to appeal the denial. You may review pertinent documents and submit

issues and comments in writing in support of the appeal. The Sponsor's decision on appeal acting through its delegate will be made generally within 60 (and not more than 120) days after receiving the appeal. That decision will be final and binding on participants, dependents and any other interested party.

In no event will a participant or his family members be entitled to challenge a decision of the Sponsor in court or in any other administrative proceeding unless and until the claim and appeal procedures authorized under the Plan and summarized above have been complied with and exhausted.

MISCELLANEOUS INFORMATION

COBRA Rights

Upon a "qualifying event" such as a termination of employment or divorce, as set forth in the Plan document, the Sponsor will inform the eligible individual how he may continue to participate in the Health Care Reimbursement Plan by making contributions to the Plan on an after-tax basis. An eligible individual who continues to participate in the Medical Expense Reimbursement Plan will be charged the maximum COBRA monthly premium permitted by law. Your COBRA rights are fully set forth in Appendix B.

Protection Against Creditors

To the extent permitted by law and except for monies owed the Sponsor, no Plan benefit payment shall be subject in any way to alienation, sale, transfer, assignment, garnishment, execution, or encumbrance of any kind and any attempt to accomplish the same shall be void.

Sponsor Authority

The Plan Administrator has the discretion to interpret the Plan and to decide all matters arising in connection with the administration of the Plan including the discretionary authority to make factual determinations. The Sponsor may adopt uniform rules for the administration of the

Plan from time to time as necessary or appropriate.

APPENDIX A

Eligible Expenses

MEDICAL	DENTAL/VISION	MISCELLANEOUS MEDICAL
Acupuncture	Braces	Ambulance
Birth control pills	Contact lenses	Braille books/magazines
Chiropractor fees	Dental examinations	Car controls for the disabled
Co-insurance amounts you pay	Eyeglasses	Hearing devices/batteries
Crutches	Eye examinations	Physician prescribed weight loss/programs
Dermatologist fees	Solutions for contact lens maintenance	Seeing-eye dog and its upkeep
Medical deductibles you pay		Telephone for the deaf
Nurse's fees		Television audio display equipment for the deaf
Psychiatrist/psychologist fees		Tuition fees for schools or homes for the disabled
Sterilization fees		
Vaccinations		
Vitamins by prescription		

Below is a sample list of eligible expenses for which you may be reimbursed from your Health Care Reimbursement Account:

Non-Reimbursable Expenses

Below is a sample list of ineligible expenses for which you may not be reimbursed from your Health Care Reimbursement Account:

- Over-the-counter medicines and drugs
- Toothpaste
- Maternity clothes
- Antiseptic diaper service
- Funeral, cremation or burial, cemetery plot, monument, mausoleum
- Illegal operations or drugs
- Divorced spouse's medical bills
- Special food or beverage substitutes
- Bottled water bought to avoid drinking fluoridated city water
- Health programs offered by resort hotels, health clubs, and gyms
- Domestic help
- Deductions from wages for sickness insurance under state law
- All premiums, including but not limited to premiums for employee's health plan coverage, the employer of the employee's spouse or dependent health plan coverage, life insurance, disability, double indemnity, "loss of earnings," insurance policies, etc.
- Athletic club expenses to keep physically fit
- Tattooing; ear piercing
- Boarding school fees paid for healthy child while parent is recuperating from illness
- Tuition and travel expenses to send a problem child to a particular school for a beneficial change in environment
- Transportation costs of a disabled person to and from work
- Travel costs to favorable climate when you can live there permanently
- Dance lessons advised by doctors as physical and mental therapy or for the alleviation of varicose veins or arthritis
- Scientology fees
- Cost of divorce recommended by psychiatrist
- Cost of hotel room suggested for sex therapy
- Marriage counseling fees
- Veterinary fees for pet
- Babysitting fees to enable you to make doctor's visits
- Weight reduction or stop smoking programs undertaken for general health, not for specific ailments

- Cost of moving away from airport noise by person suffering nervous breakdown
- Cosmetic surgery
- Hair transplants

APPENDIX B

Cobra and Other Continuation of Coverage

Cobra Eligibility

A. A plan member who becomes a qualified beneficiary shall have COBRA continuation of coverage. COBRA coverage shall be provided only where timely election of coverage and timely payment of any required contribution is made.

B. A "qualified beneficiary" means a plan member who loses coverage under one the Flexible Spending Account Plans, excluding the Dependent Care Reimbursement Account, because of a qualifying event or any child born to or placed for adoption with the employee during a period of COBRA continuation coverage.

C. "Qualifying event" for an employee means loss of coverage due to termination of employment or reduction of hours worked for reasons other than discharge for gross misconduct. "Qualifying event" for any other plan member means loss of coverage due to one of the following events:

1. Death of the employee.
2. A qualifying event for the employee.
3. Divorce or legal separation.
4. The employee becomes entitled to benefits under Medicare after the effective date of COBRA coverage.
5. A dependent child ceasing to qualify as a "Dependent."

Cobra Notices

A. The employee must notify the Plan Administrator within 60 days of any of the following Qualifying Events:

1. Divorce or legal separation.
2. A Dependent child ceasing to qualify as a "Dependent."
3. Approval of total and permanent disability by the Social Security Administration.

The plan administrator shall notify the COBRA administrator within 14 days of receipt of the employee's notice.

B. The employer shall notify the COBRA administrator within 30 days of any other qualifying event.

C. The COBRA administrator shall notify the qualified beneficiary regarding the beneficiary's coverage continuation option within 14 days of the date the COBRA administrator receives notice of the qualifying event. The notice to the qualified beneficiary shall be in a form and shall contain the information required by COBRA.

D. Notification to the employee is deemed notification to all other qualified beneficiaries residing with the employee. Notification to the parent is deemed notification to all minor qualified beneficiaries residing with the parent.

Cobra Election

A. A qualified beneficiary may elect COBRA coverage during the 60 day period immediately following the latter to occur of the date coverage under the applicable benefit program terminates or the date the qualified beneficiary receives notice from the COBRA administrator. A parent with whom a minor qualified beneficiary resides shall be the person authorized to elect coverage on behalf of the minor.

Cobra Premium Contribution

A. The plan member shall be entitled to COBRA coverage only if the contribution determined by the company is timely paid on behalf of the plan member.

B. The company may require a contribution up to 102% of the applicable benefit program cost except that a contribution up to 150% of such cost may be required for a plan member who has been approved by the

Social Security Administration for total and permanent disability benefits. The company shall determine the required contribution in advance for a period of at least 12 months.

C. Contributions on behalf of plan members shall be payable monthly.

D. For the initial contribution on behalf of a plan member to be timely, it must be paid within 45 days of the date of election of coverage continuation.

E. For any subsequent contribution to be timely, the contribution must be paid within 30 days of the due date for the month.

Extent of Cobra Coverage

A. A qualified beneficiary may continue the same coverage under the applicable benefit program as the coverage that is available to similarly situated plan members who have not experienced a qualifying event.

B. If coverage under a benefit program is modified for plan members similarly situated to a qualified beneficiary, the modification in coverage shall also apply to the qualified beneficiary.

End of Cobra Coverage

A. COBRA coverage ends on the earliest of the following:

1. The end of:

a. 18 months in a case where the qualifying event was termination of employment or reduction in hours;

b. 29 months in a case where the qualified beneficiary has been determined under the Social Security Act to have been totally and permanently disabled within 60 days from the termination of employment or reduction of hours (Nondisabled dependents are also entitled to the 29 month coverage period.)

c. 36 months for other qualifying events.

2. The date on which the Employer ceases to provide any group health plan to any Employee.

3. The date on which coverage ceases under the Benefit Program because the Qualified Beneficiary failed to make timely payment of any required contribution.

4. After the date of election, the date on which the Qualified Beneficiary first becomes either:

a. Covered, as a participant or otherwise, under any other group health plan provided the other coverage begins after the date of the Qualifying Event. COBRA coverage shall not end, however, but shall extend through any period that a pre-existing condition limitation in the other plan materially restricts benefits for the Beneficiary, or

b. Entitled to Medicare provided the Medicare entitlement occurs after the date of the qualifying event. This provision shall not apply, however, in the case of entitlement to Medicare due to end stage renal disease.

B. The following special conditions shall apply:

1. In case of a plan member other than the employee, the continuation period may be extended to a maximum of 36 months if another qualifying event occurs within the 18 month period applicable to the participant.

2. Any period of extended coverage for military leave under USERRA shall be applied to and reduce the period of available COBRA continuation for the same time periods.

3. In the event that a participant elects COBRA coverage under the Medical Expense Reimbursement Plan component of the URA/ Fermilab Flexible Benefits Plan, COBRA coverage shall terminate, at the latest, on the last day of the Plan Year in which the qualifying event

occurred.

Under no circumstances shall coverage continuation be provided for more than 36 months after the date of the original Qualifying Event.

COBRA Administration

A. COBRA administration shall be interpreted and applied in a manner consistent with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Other Continuation of Coverage

Coverage under each benefit program shall be continued on the same terms as actively employed in the situations and to the extent set forth below:

A. Disability, Worker's Compensation or Personal Leave. Coverage is continued during worker's compensation, disability, or personal leave to the extent determined by the company in its personnel practices and policies communicated to employees.

B. Military Leave. For purposes of this Article V, an employee who is absent from work in order to fulfill a period of duty in the uniformed services experiences a "qualifying event" as of the first day of such employee's absence for such duty. Such employee and any other covered dependents shall be treated as any other qualified beneficiary under Article V for all purposes of COBRA, except that when the employee's period of military leave is less than 31 days, the employee may not be required to pay more than the employee share of such coverage.

   Uniformed services means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

C. Family and Medical Leave. Coverage is continued during leave under the Family and Medical Leave Act provided the employee timely pays any required contributions.

GROUP DENTAL PLAN

CIGNA Preferred Provider (PPO)
CIGNA Dental Health (HMO)

INTRODUCTION

Universities Research Association, Inc./Fermi National Accelerator Laboratory has arranged with Connecticut General, a CIGNA company, to include a dual option dental plan in its benefit program. The two dental plans are the CIGNA Preferred Provider Plan (PPO) and the CIGNA Dental Health Plan (CDH).

The Preferred Provider Plan allows you to go to any licensed dentist or specialist of your choice. However, when you go to a dentist or specialist in the preferred provider network, you will save yourself some money. Your co-insurance cost will be less because of the discount arrangement between Connecticut General and the participating providers in the network.

The Preferred Provider Plan has a deductible and annual maximum of benefits. In the PPO Plan preventive and diagnostic care is paid at 100% of the contracted fee for participating provider care, restorative care is paid at 80% of the contracted fee for participating provider care and major restorative care is paid at 50% of the contracted fee for participating provider care.

When you receive services from a non-participating provider, preventive and diagnostic care is paid at 100% of reasonable and customary charges, restorative care is paid at 80% of reasonable and customary charges and major restorative care is paid at 50% of reasonable and customary charges.

The CIGNA Dental Health Plan is a health maintenance organization (HMO). You must select a primary care dentist under contract with the HMO. Referrals to specialists are arranged through the primary care dentist. There are no claim forms and no costs to you for diagnostic, preventive and many basic dental services and reduced fees for complex dental services.

WHO IS ELIGIBLE

All employees and their dependents except dayworkers and summer employees are eligible to enroll for dental coverage as of the first day of employment.

If both husband and wife are employees of Fermilab, one may elect to be covered as a dependent of the other for dental coverage; or both can elect to be covered as employees. Dependent children whose parents are both employees of Fermilab may be covered under one plan only.

Who is an eligible dependent

- Your lawful spouse.
- Your unmarried child who is less than 19 years old.
- Your unmarried child who is less than 23 years old, a full-time student and primarily supported by you.
- Your unmarried child who is mentally or physically incapable of earning a living may be continued beyond age 19, if 60 days before they reach the age limit, you submit proof of the child's incapacity to the Preferred Provider plan or the CIGNA Dental Health plan. Proof of the child's dependency may be required once a year.

Definition Of Dependent Child

Dependent child includes a child born of the employee, a child legally adopted by the employee, and stepchild of the employee living with the employee in a normal parent-child relationship.

If a qualified medical child support order is issued for your child, that child will be eligible for coverage as required by the order, and you will not be considered a late enrollee for dependent coverage. A qualified medical child support order is a judgement, decree or order issued by a court of competent jurisdiction and satisfies all of the rules to make it a qualified order. For details, see your group dental insurance certificate.

ENROLLMENT

At the employee orientation meeting on your first day of employment you can elect to enroll yourself and your family in one of the dental plans.

If you fail to enroll yourself or your family in the PPO plan within 30 days from your first day of employment or within 30 days from acquiring a dependent, the coverage will not be effective until Connecticut General/ CIGNA agrees in writing to insure you or your family.

If you fail to enroll yourself or your family in the CDH plan within 30 days from your first day of employment or within 30 days from acquiring a dependent, you will have to wait until the "open enrollment" period to enroll in the CDH plan.

Effective Date of Coverage

Your coverage and your family's coverage will be effective on the day you enroll, but no earlier than the day you and your family become eligible.

Late Enrollment

No dental examination will be required if you elect coverage for yourself and your family within 30 days from your first day of work or within 30 days from acquiring a dependent. If you elect coverage after that time you will be required to submit evidence of insurability before coverage is effective under the PPO plan. The CDH plan does not accept late enrollments. Coverage under the PPO plan will be limited as described in the Missing Teeth and Late Entrance section of this booklet.

Open Enrollment

Fermilab has an annual open enrollment in order for active employees to transfer dental coverage between the PPO dental plan and CDH dental plan. The annual open enrollment is held provided there is an approved alternate plan available.

Changing Plans

If you elect to transfer your coverage during an Open Enrollment Period, you will become insured under the new plan that you elect on the first day of the month after the end of the Open Enrollment Period. **However, if you or your dependent has started a program of orthodontic treatment under either plan, you may not elect to transfer from one option to the other until the Open Enrollment Period that follows six months after completion of the orthodontic treatment. In addition, any dental treatment started and not completed under one plan will not be covered under the other plan.**

If you are insured under the CDH plan, you may transfer to the PPO plan at any time should: (a) your designated dental facility terminate its contract with CDH, and no other CDH dental facility is available in the service area; or (b) you relocate outside the CDH service area. Your new coverage will be effective on the date the dental facility terminates, or the date of your move outside the service area, provided that as of that date you sign a new enrollment form for the PPO plan.

Cost

Fermilab pays for the major portion of the cost of dental coverage. Your monthly cost for single coverage under the PPO plan is $7.49 and under the CDH plan $7.63. Your monthly cost for family coverage under the PPO plan is $38.62 and under the CDH plan, $21.72.

(These are the rates effective on 10/1/02 and are subject to change.)

OUTLINE OF THE PREFERRED PROVIDER PLAN

In order for dental procedures to be covered under the PPO plan, the patient must be enrolled in this plan. The patient can receive services from any dentists or specialists of choice. However, if you use a preferred provider, your cost will be less. A list of preferred providers is available at **www.cigna.com/dental** or from the Fermilab Benefits Office.

There are four classes of services. The maximum that the plan pays for Class I, II, & III procedures is $1,500 per person per calendar year. Following is a sample of some services provided under each class. You should consult your ***Group Dental Insurance Plan*** certificate for a detailed list.

Class I - Diagnostic & Preventive Procedures

a. No deductible.

b. Plan pays 100% of reasonable and customary charges for non-participating provider care or 100% of the contracted fee for participating provider care:

- Oral exams - two per person per year
- Cleaning - two per person per year
- Bitewing x-rays - two per person per year
- Complete series of x-rays - one per person in any 3 calendar years
- Emergency treatment to relieve pain when no other definitive dental service is performed
- Fluoride treatment - one per person per year (limited to persons under age 19)
- Space maintainers (limited to non-orthodontic treatment)

Class II - Basic Restorative Procedures

a. $50.00 deductible per person per calendar year (limited to 3 per family)

b. Plan pays 80% of reasonable and customary charges for non-participating provider care or 80% of the contracted fee for participating provider care:

- Amalgam filling
- Root canal therapy
- Simple extraction
- Surgical extractions
- Periodontal scaling and root planing

Class III - Major Restorative Procedures

a. Common deductible with Class II procedures

b. Plan pays 50% of reasonable and customary charges for non-participating provider care or 50% of the contracted fee for participating provider care:

- Crowns
- Dentures
- Bridges

Class IV- Orthodontic Procedures

a. Limited to dependent children under age 19

b. No deductible

c. Plan pays 50% of reasonable & customary charges for non-participating provider care or 50% of the contracted fee for participating provider care:

d. Lifetime maximum of $1,500

OUTLINE OF THE CIGNA DENTAL HEALTH PLAN

In order for dental procedures to be covered under the CDH plan, the patient must be enrolled in this plan and receive services from the primary dentist under contract with CDH. Dental services provided by specialists will be covered when the patient has been referred by the primary care dentist to specialists under contract with CDH. A list of CDH providers is available at **www.cigna.com/dental** or Fermilab's Benefits Office.

Following are some covered procedures, and the amount that the patient would pay under patient charge schedule F1-03 (4/00). Consult your ***Group Dental Insurance Plan*** certificate or Fermilab's Benefits Office for a detailed list. (The patient charge schedule is subject to annual review and change.)

Diagnostic/Preventive Procedures	***Patient Cost***
Oral exams, once each 6 months	No Charge
X-rays	No Charge
Cleaning, once each 6 months	No Charge
Fluoride treatment, once each 6 mos, dependent child up to age 19	No Charge
Space maintainer - fixed	No Charge
Restorative Procedures	***Patient Cost***
Amalgam fillings 1, 2, 3 or 4 surfaces	No Charge
Anterior or bicuspid root canal	No Charge
Molar-root canal (one)	$200.00
Simple extraction & soft tissue impaction	No Charge
Partial bony impaction	$45.00
Complete bony impaction	$80.00
Major Restorative Procedures	*Patient Cost*
Crown and Bridge	
Porcelain or ceramic crown per unit	$335.00
Porcelain fused to metal crown per unit	$325.00*
Pontic, porcelain fused to metal per unit	$325.00*
Dentures	
Partial upper or lower w/clasps	$340.00
Complete upper or lower denture (standard)	$300.00

*There will be an additional charge for multiple crown units—ask your dentist for guidelines.

Orthodontics	***Patient Cost***
Evaluation	$ 40.00
Treatment plan & records	$150.00
Therapy for a normal 24 mo. fully banded case:	
Children to age 19	$1,600.00
Adults	$2,200.00

Services Not Covered - PPO Plan & CDH Plan

Check your Group Dental Insurance Plan certificate for a detailed list of exclusions and limitations that are unique to the particular plan.

No payment will be made for expenses incurred by you or your dependents for:

- treatment started and not completed under one plan will not be covered under the other plan;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a hospital;
- services performed solely for cosmetic reasons;
- any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards;
- services in connection with an injury arising out of, or in the course of, any employment wage or profit;
- replacement of a lost or stolen appliance;
- procedures, appliances or restoration whose main purpose is to a) change vertical dimension, or b) diagnose or treat conditions or dysfunction of the temporomandibular joint except as specified in the patient charge schedule of the CDH plan;
- prescription drugs and the administration of sedation or a general anesthesia;
- services in connection with a sickness which is covered under workers' compensation or similar law;
- services in a hospital owned or run by the United States Government, unless the person is legally required to pay for such charges;
- services which the person is not legally required to pay;
- charges which exceed the reasonable and customary charges;
- services that you or your dependent are entitled to payment through a public program other than medicaid;
- services which are experimental procedure or treatment methods not approved by the American Dental Association or the appropriate speciality society; and
- expenses to the extent that benefits are payable under the mandatory part of any auto insurance policy written to comply with no-fault insurance law or uninsured motorist insurance law.

Missing Teeth And Late Entrant Limit

This limit applies to the PPO Plan only. Payment for the following covered dental services will be 50% of the amount otherwise payable for:

- Class III or Class IV dental services when an individual enrolls in the plan after 30 days of employment; or
- first replacement of teeth that are missing when an individual became insured for these benefits.

After an individual has been continuously insured for these benefits for 24 months, this limit will no longer apply. If an individual transfers from the CDH plan directly to the PPO plan, credit will be given for the length of time the individual was insured under CDH.

Pretreatment Review

The pretreatment review under the PPO plan is designed to give you and your dentist a better understanding of the covered expenses payable under this plan before services are provided. When charges for a proposed dental procedure or series of dental procedures are expected to exceed $200.00, your dentist should submit a claim form to the PPO plan showing the treatment plan and fees. The PPO plan will then use this pretreatment review to determine the benefits which will be payable for each dental service according to the terms of the plan and notify your dentist accordingly. You can find out the results of the review from your dentist. When the treatment plan is finished, your dentist should resubmit the claim form for payment showing the date each service was performed.

The pretreatment review is not required, but it is a good idea to know beforehand what you may be responsible to pay.

COORDINATION OF BENEFITS (COB)

When you or any one of your dependents are covered under more than one group dental plan, benefits from the PPO plan will be coordinated with the benefits from any of your other group dental plans so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid by the plans. The rules below establish the order in which benefits will be determined.

- The plan with no COB provision is always primary.
- The plan that covers the individual as an employee is primary. The plan that covers the individual as a dependent is secondary.
- The plan that covers the individual as an active employee is primary. The plan that covers the individual as a retired employee is secondary.
- The plan of the parent whose birthday falls earlier in the year is primary.
- If parents are separated or divorced, the primary plan is that of the parent who has custody. If there is a court decree designating one parent as responsible for health care expenses, that parent's plan will be primary.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following dates:

- The date you are no longer a member of an eligible class of employees.
- The date the group policy cancels.
- The date your employment terminates.
- The date you fail to make the required contributions.
- A family member's coverage terminates when the member is no longer eligible.

Extension of Benefits Following Termination of Insurance

Certain dental procedures that are in progress at the time dental benefits are terminated can be considered covered expenses if they are completed within three months from termination of insurance. (See your Group Dental Insurance Plan certificate for details.)

Rights at Termination of Insurance (COBRA)

Federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA), enables you or your covered dependents to continue dental coverage under certain circumstances when coverage would otherwise terminate. To continue dental coverage, you or your covered dependents must pay the full cost plus a 2% administrative fee.

You or your covered dependents may elect to continue dental coverage for 18 months if your coverage terminates because your employment terminates for any reason except gross misconduct. Coverage can be extended to 29 months if Social Security Administration determines that you or a covered dependent are disabled or become disabled within 60 days from the date of termination of employment.

The coverage extension is available to the disabled individual and the individuals nondisabled family members who are entitled to COBRA continuation. Premiums during the additional 11 months of coverage will be at a substantially higher rate than for the initial 18 month period (150% of the current rate.)

To qualify for the extension, you must notify Fermilab's Benefits Office in writing. In addition, you must submit a copy of the Social Security disability determination within 60 days of the date of the notice to Fermilab's's Benefits Office.

Dental coverage may be continued by covered dependents for up to 36 months if their coverage terminates because of one of the following events:

- your divorce or legal separation, or
- your child ceases to qualify.

The election form to continue dental and medical coverage is given to you at your exit interview. Otherwise it is available from the Benefits Office, 15th floor Wilson Hall, extensions 4362 or 3395.

You must elect continuation of coverage within 60 days of loss of coverage. From the date of election you have an additional 45 days to pay the required retroactive premium to avoid a gap in coverage.

If your covered dependents elect continuation coverage due to your termination of employment, they will be entitled to additional months of coverage (up to 36 months) if, during the first 18 months:

- you die,
- you divorce or legally separate,
- your child ceases to qualify as a dependent, or
- you become eligible for Medicare.

In order to be eligible for continuation of coverage, it is your or your dependents responsibility to notify the Benefits Office within 60 days from the date of these events.

Additional information regarding COBRA rights and benefits are in your Group Dental Insurance Plan certificate.

Termination of COBRA Benefits

Continuation of COBRA coverage will stop before the end of the established time period if:

- you or your dependents become covered under any other group dental plan,
- you or your dependents become eligible for Medicare,
- the required premiums are not paid within 30 days of the due date, or
- the plan is terminated

Additional information regarding termination of COBRA benefits are in your Group Dental Insurance Plan certificate.

CONVERSION PRIVILEGE

At the end of your or your dependent's COBRA continuation period, you or your dependent may be eligible to convert to an individual dental conversion policy. You may arrange for a conversion policy during the 180 day period before your or your dependent's COBRA period ends. You must apply in writing to Connecticut General and pay the first premium within 31 days after the date your COBRA coverage terminates.

If you are ineligible for COBRA benefits, you may be able to convert to a conversion policy. You must apply in writing to Connecticut General and pay the first premium within 31 days after the date group dental coverage terminates. Additional information regarding the conversion privilege is in your Group Dental Insurance Plan certificate.

LEAVE OF ABSENCE

If you are granted a leave of absence, you may continue your and your dependent's group dental coverage as long as you pay the full cost. You must notify the Benefits Office to make arrangements to continue the group dental coverage before your leave starts. Your group dental coverage will terminate at the start of your leave if you fail to elect continuation of coverage within 60 days of the start of your leave. If you elect coverage and you fail to return from leave, COBRA premiums will then apply.

If your request for a leave of absence meets the criteria for leave under the Family Medical Leave Act (FMLA), you may continue your and your dependent's group dental coverage as long as you pay the current employee deduction for such coverage. (See Fermilab's Personnel Policy Guide for details regarding FMLA).

MILITARY LEAVE

If you are absent from work in order to fulfill a period of duty in the U.S. Uniformed Services, you and your dependents shall be treated as any other qualified beneficiary under COBRA continuation of benefits. (See section "Rights at Termination of Insurance - COBRA.) If your period of military leave is less than 31 days, you will be required to pay the employee share for coverage.

LAYOFF

Dental coverage ends on your last working day. If you are eligible for severance and if the run out payout option under the severance plan is an option available to you, your dental coverage will continue to the end of the payout period as long as you pay your portion of the premiums, and the plan is not terminated. COBRA continuation rules apply concurrently with severance runout period.

DISABLED EMPLOYEES

If you are disabled and receiving benefits under the long term disability plan, you and your eligible dependents will continue to be covered under the dental plan. You must pay your portion of the required premium. If you elect early retirement, dental coverage terminates and COBRA continuation rules apply.

HOW TO FILE A CLAIM

PPO Plan

Dental claim forms are available from the Benefits Office, 15th floor Wilson Hall. You and your dentist should complete the appropriate section of the form and mail it directly to:

CIGNA Healthcare Service Center
P.O. Box 15558
Wilmington, DE 19850-5558
1-800-441-7150

The dental claim should be filed as soon as you have incurred or completed the services. The prompt filing of a completed claim form will result in faster payment of your claim.

CIGNA Dental Health Plan

There are no claim forms to complete and submit. Itemized bills for emergency treatment should be submitted to your primary care dentist for processing.

GRIEVANCE PROCEDURES

PPO Plan

The procedure is described in the ERISA Information Section of this booklet. All complaints can also be directed to the Illinois Insurance Department, Consumer Services Section, 320 West Washington, Springfield, Illinois 61767.

CIGNA Dental Health Plan

If you have questions about your treatment plan or the care process, you can call or write to:

CDH Professional Relations Department
P.O. Box 18906
Plantation, FL 33318-9060
1-800-367-1037

In addition all complaints can be directed to the Illinois Insurance Department, Consumer Services Section, 320 West Washington, Springfield, Illinois 61767. ERISA rights apply as described in the ERISA Information Section of this booklet.

ERISA INFORMATION

Plan Name

Dental Insurance

Plan Number

506

Employer Identification Number

52-0816670

Plan Sponsor

Universities Research Association, Inc.
(Fermi National Accelerator Laboratory)

Type of Plan

Welfare

Plan Year Ends

The benefit plan records are kept on a calendar year basis. The plan year ends each December 31.

Plan Administrator

Head, Laboratory Services
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, Illinois 60510
(630) 840-3396

Plan Fiduciary

Vice President
Universities Research Association, Inc.
Suite 400
1111 19th Street N.W.
Washington, D. C. 20036

Agent For Services of Legal Process

Plan Administrator and/or Plan Fiduciary

Plan Cost

Paid by the employer and employee.

Effective Date

April 1, 1979.

Benefits Provided By

CIGNA
Connecticut General Life Insurance Company
195 Broadway 12th Floor
New York, NY 10007

Eligibility

All active employees and their eligible dependents except dayworkers and summer employees.

Loss of Benefits

You and your eligible dependents must continue to be a member of an eligible class and continue to make any required contributions. Universities Research Association, Inc. and Fermi National Accelerator Laboratory maintain

the right through the Plan Administrator to modify, amend or terminate the dental plan described in this booklet.

Collective Bargaining Agreements

Benefit information can be found in the following labor agreements.

- Local No. 113, International Association of Machinists (AFL-CIO): Machinist and Welders.
- Local No. I-21, International Association of Fire Fighters (AFL-CIO): Fire Fighters.
- Local No. 113, International Association of Machinists (AFL-CIO): Computer Operators.
- Local No. 113, International Association of Machinists (AFL-CIO): Electricians and Mechanics.

Requests For Information and Claim Procedures

Request for information and claims concerning eligibility, participation, contributions, or other aspects of the operation of any plan should be directed to the Plan Administrator.

If a written request or claim is denied, the Administrator shall, within a reasonable time, provide a written denial to the participant. It will include the specific reasons for denial, the provisions of the plan upon which the denial is based, a description of any material needed to complete the claim (if appropriate) and why it is necessary, and instructions on how to apply for a review of the claim. When the Administrator requires additional time to process a claim because of special circumstances, an extension may be obtained by notifying the participant that a decision on the claim will be delayed, what circumstances have caused the delay and when a decision can be expected. The Administrator will inform the participant of the delay within ninety days of the date the claim was submitted.

A participant may request in writing a review of a denied claim and may review pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the participant a decision upon such request for review of a denied claim within sixty days of receipt of the request. When special circumstances require an extension, the Administrator may obtain such extension by notifying the participant that the decision on the review of the denied claim will be delayed, why and when a decision can be expected. See each plan's section for specifics on how to file a claim.

Rights and Protections

The following statement of ERISA rights is required by federal law and regulation. As a participant in the retirement and welfare plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The Plan Administrator's Office is located at Robert R. Wilson Hall, 15th floor southeast.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator.

3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the

above rights. For instance, if you request materials from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Dept. of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

GROUP MEDICAL PLANS FOR ACTIVE AND RETIRED EMPLOYEES

CIGNA Preferred Provider Organization
Health Maintenance Organizations
HMO Illinois
CIGNA Point of Service

INTRODUCTION

One of the major policies of Universities Research Association, Inc. and Fermi National Accelerator Laboratory is to provide a comprehensive program of benefits for its employees. Included in the benefit program is a preferred provider organization combined with traditional indemnity insurance features and several health maintenance organizations that provide valuable protection for you and your family against the steadily rising costs of medical care. The preferred provider organization plan is underwritten by Connecticut General Life Insurance Company, and the health maintenance organizations in the program are CIGNA Point of Service and HMO Illinois. You should elect the plan that best meets your needs.

The Connecticut General CIGNA Preferred Provider Organization Plan (PPO) is designed to integrate two types of medical plan designs in one. It is designed to include features found in the traditional indemnity medical insurance plan, and the features found in a managed care plan. When you need medical care, you can use this plan in the way that fits you best. You can go "in-network" and visit a preferred provider at a cost savings, or you can go "out-of-network" and use any provider of your choice, but your cost will be more.

The Health Maintenance Organizations are designed to provide full coverage for most expenses when you are sick or injured, and also cover routine and preventive care. When you join an HMO plan, you must select a primary care doctor under contract with that HMO, and almost all referrals to specialist and hospitals are arranged through the primary care doctor. Most services are paid in full, and the lifetime maximum benefit for you and each of your covered dependents is unlimited.

GLOSSARY OF TERMS

Assignment of benefits: a claimant request that benefits under a claim be paid to some designated person or institution, usually a physician or hospital.

Coinsurance: is a cost sharing arrangement between the health plan and the covered person. For example: a plan may pay 80% of covered charges then the covered person pays 20%. Often coinsurance applies after first meeting the health plan deductible requirement.

Copayment: also called copay, is a cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit, and the health plan pays the balance of the charge. Typical copayments are fixed or variable flat amounts for physician office visits and prescription drugs.

Covered person: an individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual agreement.

Deductible: the amount of eligible expenses a covered person must pay each year from his/her own pocket before the health plan will make payment for eligible benefits.

Drug formulary: a listing of prescription medications which are preferred for use by the health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan.

Explanation of benefits (EOB): the statement sent to covered persons by their health plan listing services provided, amount billed and payment made or denied.

Generic drug: a chemically equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or generic name for that drug (e.g. the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam).

Health maintenance organization (HMO): see definition in the “Introduction” section of this booklet.

Medicaid: a federal program administered and operated individually by participating state and territorial governments which provides medical benefits to eligible low income persons needing health care. The federal and state governments share the program’s costs.

Medicare: a nationwide, federally administered health insurance program which covers the costs of hospitalization, medical care and some related services for eligible persons. To be eligible you must either be disabled and receiving Social Security income for 24 months or be age 65.

Medicare carve-out plan: a method of integrating Medicare with an employer's retiree health plan (making the employer plan secondary). The employer's retiree health plan is designed to supplement Medicare to the level of coverage provided to active employees. For example, when Medicare pays a claim, the employer's retiree health plan will not pay if Medicare has paid a benefit equal to the level that would have been paid to an active employee. Generally, an employer's Medicare carve-out plan will pay benefits after the retiree has satisfied the health plans deductible and out-of-pocket limit.

Out-of-pocket limit: the total payment toward eligible expenses that a covered person funds, i.e. deductibles, co-pays and coinsurance – as defined per the contract. Once this limit is reached, benefits will increase to 100% for health services received during the rest of that calendar year. Some out-of pocket costs (e.g. mental health, penalties of non-pre-certification, etc.) are not eligible for out-of-pocket limits. (See the insurance certificates for details.)

Participating Network provider: a provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility or physician who has contractually accepted the terms and conditions as set forth by the health plan. Participating provider is also known as being an in-network provider.

Point of Service Plan: a health plan allowing the covered person to choose to receive a service from a participating or non-participating provider with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways: an HMO may allow members to obtain limited services from non-participating providers; a PPO may be used to provide both participating and non-participating levels of coverage and access.

Preferred Provider Organization (PPO): see definition in the "Introduction" section of this booklet.

Utilization review: a formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

SEE THE PPO AND HMO BOOKLETS AND/OR INSURANCE CERTIFICATES FOR ADDITIONAL DEFINITIONS.

PREFERRED PROVIDER PLAN

The PPO plan pays benefits on the basis of "reasonable and customary charges" and "medically necessary" for the diagnosis and treatment of an illness, injury or pregnancy. The following is a summary of the plan. For details and definitions please refer to your *Group Insurance Plan* certificate.

Your costs will be lower when you use physicians and health facilities that are in the preferred provider network. A directory is available from Fermilab's Benefits Office, but it is highly recommended that you call the **CIGNA TOLL-FREE CARE LINE AT 1-800-438-0247 or access CIGNA's website at www.cigna.com/healthcare** to get the most current information on provider's network status.

Inpatient Hospitalization (In- and Out-of-Network)

Pre-admission Certification & Continued Stay Review is required for all inpatient hospitalizations. Non-emergency admissions must be pre-approved by calling the **CIGNA Toll-Free Care Line at 1-800-438-0247.** Emergency admissions must be reported within 24 hours of hospitalization. Failure to report the hospital stay or remaining in the hospital beyond the medically necessary days will reduce the hospital payment by 50% up to a $1,000.00 penalty and/or the cost of not-approved days. **(Details of the PAC/CSR requirement are in your Group Insurance plan.)**

PREFERRED PROVIDER PLAN SCHEDULE OF BENEFITS

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$200	$400
Family	$600	$1200
	Cross accumulated	
Annual Calendar Year Out-of-Pocket Maximum (Excludes Deductible and Ineligible Expenses)		
Individual	$1,000	$2,000
Family	$3,000	$6,000
	Cross accumulated	
Individual Lifetime Maximum Benefit		
	$2,000,000 combined	
Hospital Inpatient Benefits		
Room & Board (semi-private)	90%	80%
Ancillary Charges	90%	80%
Hospital Outpatient Benefits		
Hospital Charges	90%	80%
Physician Charges	90%	80%
Surgery Benefits		
Inpatient	90%	80%
Outpatient	90%	80%
Physician Benefits		
Hospital Visits	90%	80%
Office Visits	$15 copay, 100%	80%
Chiropractor Visits	$15 copay, 100%	80%
Diagnostic X-Ray & Lab Benefits		
Billed by physician's office	100%	80%
Billed by other provider	90%	80%
Maternity Benefits	90%*	80%*
New Born Benefits		
Hospital Nursery	90%	80%
Well Baby Care Doctor's office visits to age 2	$15 copay, 100%	No coverage

	In-network	Out-of-network
Mental Illness Treatment		
Inpatient	90%	80%
Outpatient	90%	80%
Maximum outpatient benefit per calendar year	30 visits (combined)	30 visits
Substance Abuse Treatment		
Inpatient	90%	80%
Outpatient	90%	80%
Maximum outpatient benefit per calendar year	30 visits (combined)	30 visits
Routine Services		
Physical exam one per calendar year after age 2	$15 copay, 100%, $300 max.	Not covered
Eye exams	Not covered	Not covered
Eye Glasses or Contacts	Not covered	Not covered
Hearing Exams & Aids	Not covered	Not covered
Prescription Drug Benefits		
Generic Drugs (30 day supply)	$15 copay, 100%	80%
Brand name drugs with no generic equivalent (30 day supply)	$15 copay, 100%	80%
Mail order 90-day supply	$30 copay, 100%	n/a
Brand name drugs (30 day supply)	$15 copay, + price difference between generic & brand name drug.	80%

Not all prescriptions are covered. Check with the PPO claims office and RX Prime, the prescription card administrator.

HEALTH MAINTENANCE ORGANIZATION PLANS
SCHEDULE OF BENEFITS

	HMO IL	**CIGNA POINT OF SERVICE PLAN**	
	PRIMARY CARE PHYSICIAN MUST APPROVE TREATMENT IN ORDER FOR CHARGES TO BE COVERED AT THE FOLLOWING LEVELS.		
Hospital Inpatient Benefits		*In-Network*	*Out-of-Network**
Room & Board (semi-private)	100%	100%	70%
Ancillary charges	100%	100%	70%
Hospital Outpatient Benefits			
Emergency Hospital Charges	100%	100%	70%
	You must follow the emergency procedure described in each Plan's literature. A co-payment may apply.		
Emergency Doctor Charges	100%	100%	70%
	You must follow the emergency procedure described in each Plan's literature. A co-payment may apply.		
Surgery Benefits			
Inpatient	100%	100%	70%
Outpatient	100%	100%	70%
Physician Benefits			
Hospital Visits	100%	100%	70%
Office Visits	$15 copay per o.v., 100%	$15 copay per o.v., 100%	
Chiropractor	May be covered with a referral		70%
Diagnostic X-Ray & Lab Benefits	**100%**	**100%**	**70%**

* Subject to calendar year deductible. (See Group Insurance Certifiate for details)

HEALTH MAINTENANCE ORGANIZATION PLANS
SCHEDULE OF BENEFITS (cont.)

	HMO IL	CIGNA POINT OF SERVICE PLAN	
Maternity		*In-Network*	*Out-of-Network**
Inpatient	100%	100%	70%

The hospital stay following a normal delivery may generally not be limited to less than 48 hours for both mother and newborn; and may not be limited to less than 96 hours following a Cesarean Section.

Newborn Benefits			
Hospital Nursery	100%	100%	70%
Well Baby Care	$15 copay per o.v., 100%	$15 copay per o.v., 100%	Not covered in out-of-network
Mental Illness Benefits			
Inpatient	100% 20 days	$25 per day copay, 30 days (Combined)*	70% 30 days
Outpatient 20 visits per yr.	$20 copay per o.v.,	$15 copay per o.v., 30 visits per yr. (Combined)*	70% 30 visits per yr.
Alcohol & Drug Abuse Benefits			
Inpatient	100%, 20 days	100%, $25 per day copay, 30 days (Combined)*	70% 30 days
Outpatient	$20 copay per o.v., 20 visits per yr.	$15 copay per o.v., 60 visits per yr. (Combined)*	70% 60 visits per yr.
Prescription Drug Benefits			
Individual pays per prescription and per refill. (30 day supply)	$10 copay, generic $15 copay brand-name formulary $30 copay brand-name non-formulary	$10 copay generic $10 copay non-generic plus price difference between generic and brand name drug	70%

(THE PLANS DO NOT ALWAYS COVER ALL PRESCRIPTIONS. CHECK THEIR BOOKLETS FOR DETAILS.)

* Maximum number of days and visits applies to the combination of in-network and out-of-network.

HEALTH MAINTENANCE ORGANIZATION PLANS
SCHEDULE OF BENEFITS (cont.)

	HMO IL	CIGNA POINT OF SERVICE PLAN	
Routine Services		*In-Network*	*Out-of-Network**
Physical Exams	$15 copay, 100%	$15 copay, 100%	Not Covered
Immunizations & Inoculations	100%	100%	Not Covered
Eye Exams	$15 copay, 100%	$15 copay, 100%	Not Covered
Eye Glass Discount	$75.00 allowance every 24 months	Not Covered	Not Covered
Hearing Exams	100%	100%	Not Covered
	(HEARING AIDS OR THE EXAMINATION FOR THE FITTING OF HEARING AIDS ARE NOT COVERED.)		
Allergy Test &Treatment	100%	100%	70%

GENERAL LIMITATIONS AND EXCLUSIONS - PPO & HMO(s)

Note: Check your PPO Insurance certificate, POS Insurance Certificate or your Health Maintenance Organization booklet for a detailed list of limitations and exclusions as they apply to their plans.

No payment will be made for expenses incurred by you or your dependents:

- For medical service provided before your insurance effective date;
- For occupational accidents or sickness covered by Worker's Compensation or any other program including Medicare;
- For charges in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For charges which the employee or dependent is not legally required to pay;
- For charges which would not have been made had insurance coverage not existed;
- For expenses which exceed reasonable and customary charges for the locality in which they are incurred;
- For unnecessary care or treatment;
- For expenses that are otherwise payable under the coordination of benefits provision;
- For expenses that are reimbursable through third party liability;
- For expenses in connection with cosmetic surgery (Cosmetic surgery is covered under certain situations. Refer to your plan's booklet for details.);
- For eyeglasses, hearing aids or examinations for prescription or fitting thereof (The HMO covers eye exams and eyeglasses. The POS covers eye exams. Refer to your plan's booklet for details.);
- Services received without a referral from the HMO primary physician (Does not apply to self referral to an obstetrician or the PPO).
- For dental treatment (Dental treatment is covered under certain situations. Refer to your plan's booklet for details.);
- For charges in connection with custodial care, education or training;
- For experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution-limited by Federal law to investigational use."

- For experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society.
- Not all prescriptions are covered; check with the plan in which you are enrolled.

Women's Health and Cancer Rights

The 1998 federal Women's Health and Cancer Rights Act requires all health plans to cover reconstructive surgery following a mastectomy. When a covered person receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the medical plan must cover:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance;
- prostheses and physical complications in all stages of mastectomy, including lymphedema.

For additional information please refer to the plan's certificate.

Who Is Eligible

All employees and their dependents except dayworkers and summer employees are eligible to enroll for medical coverage as of the first day of employment.

All retirees and their dependents who meet the retirement eligibility requirements are eligible. (Refer to the retiree medical section of this booklet for details.)

If both husband and wife are employees of Fermilab, one may elect to be covered as a dependent of the other for medical coverage, or both can elect to be covered as employees. Neither can be covered as both an employee and a dependent. Dependent children whose parents are both employees of Fermilab may be covered under one plan only.

Who Is An Eligible Dependent

PPO and Health Maintenance Organizations

- Your lawful spouse.
- Your unmarried child who is less than 19 years old.
- Your unmarried child who is less that 23 years old, primarily supported by you and enrolled in school as a full-time student.
- Your unmarried child who is mentally or physically incapable of earning a living may be continued beyond age 19, if 60 days before he or she reaches the age limit, you submit proof of the child's incapacity to the PPO or the HMO. Proof of the child's dependency may be required once a year.
- It is your responsibility to notify Fermilab's Benefits Office when one of your dependents is no longer eligible for coverage. They may be eligible for continuation of coverage. (See section "Rights at Termination of Coverage.")

Definition of a Dependent Child

PPO and POS

Child includes a child born of the employee, a child legally adopted by the employee and a stepchild of the employee living with the employee in a normal parent-child relationship.

HMO IL

See your HMO IL booklet for details.

Qualified Medical Child Support Order

If a qualified medical child support order is issued for your child, that child will be eligible for coverage as required by the order, and you will not be considered a late enrollee for dependent coverage. A qualified medical child support order is a judgement, decree or order issued by a court of competent jurisdiction and satisfies all of the rules to make it a qualified order. For details see your PPO insurance certificate, POS insurance certificate or HMO IL certificate.

Enrollment

At the employee orientation meeting on your first day of employment you can elect to enroll yourself and your family in one of the medical plans.

If you fail to elect medical coverage for yourself or your family within 30 days from your first day of employment you will have to wait until the next open enrollment period. Under some circumstances, you may be able to enroll without waiting for an open enrollment period. (See section "Special Enrollment.")

Effective Date of Coverage

Your coverage and your family's coverage will be effective on the day you enroll, but no earlier than the day you and your family become eligible.

Dependent Enrollment

You have 30 days after you acquire a dependent to enroll that dependent in the plan. If you fail to do so, you will have to wait for the next open enrollment period.

Open Enrollment

Fermilab has an annual open enrollment in order for ***active employees*** to transfer medical coverage, enroll in a medical plan or add dependents to a medical plan. The annual open enrollment is held provided there is an approved alternate plan available. The open enrollment period lasts 10 working days.

Exceptions for Newborns

A dependent child born while you are insured for single coverage will become insured on the date of the child's birth. If you do not elect family coverage to insure your newborn within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Note: If you already have family coverage on the birth date of your newborn child, you should notify the Benefits Office no later than 31 days from the child's birth so the Benefits Office can report your child as an eligible dependent.

Special Enrollment

You can enroll yourself and your dependents in a medical plan without waiting for an open enrollment period if:

- You decline Fermilab medical coverage because you have other medical coverage, then you lose the other coverage because you are no longer eligible, or because the employer failed to pay the required premium. **In such cases, you must enroll in a laboratory medical plan within 30 days after losing the other coverage**. You will have to provide proof that you had other coverage.

- You decline Fermilab medical coverage because you have COBRA coverage, then you complete your COBRA coverage period. **In such cases, you must complete your entire COBRA coverage period, and you must enroll in a laboratory medical plan within 30 days after completing your COBRA coverage period.** You will have to provide proof that you completed your COBRA coverage period.

- You decline Fermilab medical coverage and then a new dependent is added to your family due to marriage, birth, adoption or placement for adoption. **In such cases, you must enroll in a laboratory medical plan within 30 days after the marriage, birth, adoption or placement for adoption.** You will have to provide proof of the event.

COST

Your monthly cost for single coverage is $41.41 PPO, $36.32 POS and $37.14 HMO and family coverage is $142.31 PPO, $126.14 POS and $126.28 HMO (10/01/02). The employee's cost is reviewed annually, and any new rate is effective at the time of open enrollment.

COORDINATION OF BENEFITS (COB)

When you or one of your dependents are covered under more than one group medical plan, benefits from all plans will be coordinated up to 100% of eligible expenses. The PPO, POS and the HMO use the following order of benefit determination:

Plans with no COB provisions are always primary.

The plan that covers the individual as an employee is primary. The plan that covers the individual as a dependent is secondary.

The plan that covers the individual as an active employee is primary. The plan that covers the individual as a retired employee is secondary. (This does not apply to retirees of URA/Fermilab. See section "Other Employment.")

The plan of the parent whose birthday falls earlier in the year is primary. For example: DOB of father is October, and DOB of mother is June. The mother's plan is primary, and the father's plan is secondary. (Year of birth is not taken into consideration.)

If parents are separated or divorced, the primary plan is that of the parent who has custody. If there is a court decree designating one parent as responsible for health care expenses, that parent's plan will be primary.

COORDINATION OF BENEFITS WITH MEDICARE ELIGIBLES

Active Employees & Dependents Age 65 And Over

If you continue working after age 65, you have the right to make one of the following elections:

- **Continue primary coverage under one of the Fermilab medical plans.** In this case the Fermilab plan will pay benefits first. If your claim is for services covered by Medicare, Medicare will pay second. You may receive from Medicare all or part of the unpaid balance of the claim, but not more than up to Medicare limits.

- **Elect primary coverage under Medicare:** In this case Medicare will pay your claims. There will be no benefits paid under any of Fermilab's medical plans.

The Benefits Office will assume that you want Fermilab's medical coverage as primary payor. If you want primary coverage under Medicare only, you must notify the Benefits Office and cancel your Fermilab medical coverage.

At least 2 months before your 65th birthday, you should notify the nearest Social Security Office and advise them that you are eligible to join Medicare Parts A & B. There is no charge to join Medicare Part A. The cost of Medicare Part B in 2000 is $45.50 per month.

Disabled Employees and Disabled Dependents of Active Employees

Active employees who are no longer able to work because of a disability and who are eligible for Medicare must join Medicare Parts A & B. Medicare becomes the primary payor, and Fermilab's medical plan becomes the secondary payor. For disabled dependents of active employees, Fermilab's plan is the primary payor, and Medicare is the secondary payor. For those individuals eligible for Medicare because of end stage renal disease, Fermilab's medical plan is primary payor for only 18 months after that time period Medicare is the primary payor for bills related to the renal disability.

Retirees & Dependents 65 And Over

When you are eligible for Medicare Parts A & B, Medicare will be your primary payor, and Fermilab's plan will be the secondary payor. Benefits paid under the plan will be reduced by Medicare's payment. (It is important that you elect Medicare coverage because Fermilab's plan will not consider charges that Medicare could pay. Refer to the retiree section of this booklet for additional information.)

PLAN'S RIGHT TO REIMBURSEMENT

If you or your dependent receive benefits for covered expenses under one of the medical plans and subsequently collect payment for the same expenses from a third party by settlement, judgement or otherwise, you or your dependent must reimburse the appropriate plan for the amount of benefits received from the third party.

TERMINATION OF COVERAGE

Medical coverage terminates on the earliest of the following dates:

- The date the employee ceases to be in a class of eligible employees or ceases to qualify as an employee.
- The date the policy is discontinued.
- The date employment terminates.
- The date premium is not paid.

Rights at Termination of Coverage

You and your covered dependents are entitled to continue medical coverage in certain cases when coverage would otherwise terminate. These circumstances are described below.

Dependent Coverage in the Event of Your Death

If you should die while in ***active service***, your covered spouse and dependents may elect to continue on the same medical plan for 36 months. Under Federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA), they can continue coverage for 36 months provided that they pay the cost for this coverage.

The cost to continue coverage for the first 12 months is the same family contribution rate the employee was paying at the time of death. (If the active employee deduction increases within that 12 month period, so will the cost to survivors up to the active employee deduction for family coverage.) The cost to continue coverage for the next 24 months is 102% of the full premium (laboratory and employee share.)

Under Illinois law if your covered spouse is 55 years old or older at the time of your death, your spouse can continue medical coverage for an additional 84 months (7 yrs.) provided the spouse pays 150% of the full cost for this coverage, is not eligible for Medicare and is not covered by another group plan.

When group medical coverage terminates, your dependents may convert to an individual policy as described in the conversion section.

Coverage for Employees And Dependents Who Become Ineligible

Federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA), enables you or your covered dependents to continue medical coverage under certain circumstances when coverage would otherwise terminate. You or your covered dependents must pay the full cost of this coverage plus a 2% administrative fee.

You or your covered dependents may elect to continue medical coverage for 18 months if your coverage terminates because your employment terminates for any reason except gross misconduct. If you elect continuation of coverage for 18 months, you or your covered dependents may be able to extend COBRA coverage from 18 months to 29 months, if Social Security Administration determines that you or a covered dependent is disabled before or within the first 60 days of COBRA continuation coverage. The coverage extension is available to the disabled individual and the individual's nondisabled family members who are entitled to COBRA continuation. Premiums during the additional 11 months of coverage will be at a substantially higher rate than for the initial 18-month period (150% of the current rate).

To qualify for the extension, you must notify Fermilab's Benefits Office in writing. In addition, you must submit a copy of the Social Security disability determination within 60 days of the date of the notice to Fermilab's Benefits Office.

Medical coverage may be continued by covered dependents for up to 36 months (up to 120 months in Illinois for spouses age 55 and over) if their coverage terminates because of one of the following events:

- your divorce or legal separation, or
- your child ceases to qualify.

The election form to continue medical coverage is given to you at your exit interview. Otherwise it is available from the Benefits Office, 15th floor Wilson Hall, extensions 4362 or 3395. You must elect continuation of coverage within 60 days of loss of coverage. From the date of election you have an additional 45 days to pay the required retroactive premium to avoid a gap in coverage.

If your covered dependents elect continuation coverage due to your termination of employment, they will be entitled to additional months of coverage (up to 36 months) if, during the first 18 months:

- you die,
- you divorce or legally separate,
- your child ceases to qualify as a dependent, or
- you become eligible for Medicare.

In order to be eligible for continuation of coverage, it is your or your dependent's responsibility to notify the Benefits Office when a dependent is no longer eligible for coverage. Notification and election to continue medical coverage must be given to the Benefits Office within 60 days from loss of eligibility.

Termination of COBRA Benefits

Continuation of coverage will stop before the end of the established time period if:

- you or your dependents become covered under any other group medical plan (as long as such group health plan does not contain any exclusion or limitation with respect to any pre-existing condition you or your dependents may have)
- you or your dependents become eligible for Medicare
- the required premiums are not paid within 30 days of the due date
- the plan is terminated
- you or your dependent is no longer disabled under the Social Security Act.

CONVERSION PRIVILEGE

At the end of your or your dependent's COBRA continuation period, you or your dependents may convert to an individual conversion policy. You may arrange for an individual conversion policy during the 180 day period before the COBRA period ends. The individual must apply in writing and pay the first premium within 31 days after the date group medical coverage terminates.

Individuals ineligible for COBRA benefits may be able to convert to an individual policy. (See details of the conversion privilege in your plan's certificate.)

CERTIFICATION OF GROUP MEDICAL PLAN COVERAGE

When your coverage terminates, you are entitled to receive documentation that certifies your Fermilab group coverage period. At your exit interview and at the end of your COBRA continuation period, you will receive a certification of group health plan coverage form detailing when you and your dependents were covered under Fermilab's medical plan. This certification form is also available upon written request.

EXTENDED BENEFITS AT TERMINATION OF COVERAGE

Preferred Provider Organization Plan

If you or a covered dependent is totally disabled at the time group coverage terminates, benefits will continue for up to 12 months after the date of termination without cost to you or your dependent for only the condition that caused total disability. If pregnancy exists on the date the PPO plan terminates, only the mother's maternity charges will be payable for that pregnancy.

To cover all other conditions and beyond the above time periods, see the section in this booklet titled "Rights At Termination of Coverage."

Point of Service and Health Maintenance Organization Plans

There are no free extended benefits for disabled individuals (including pregnancy) after the termination of group coverage. See the section in this booklet titled "Rights At Termination of Coverage."

LEAVE OF ABSENCE

If you are granted a leave of absence, you may continue your and your dependent's group medical coverage as long as you pay the full cost. You must notify the Benefits Office to make arrangements to continue the group medical coverage before your leave starts. Your group medical coverage will terminate at the start of your leave if you fail to elect continuation of coverage within 60 days from the start of your leave. If you elect coverage and you fail to return to from your leave, COBRA premiums will then apply.

If your request for a leave of absence meets the criteria for leave under the Family Medical Leave Act (FMLA), you may continue your and your dependent's group medical coverage as long as you pay the current employee deduction for such coverage. (See Fermilab's Personnel Policy Guide for details regarding FMLA.)

LAY OFF

Medical coverage ends on your last working day. If you are eligible for severance and if the run out payout option under the severance plan is an option available to you, your dental coverage will continue to the end of the payout period as long as you pay your portion of the premiums, and the plan is not terminated. COBRA continuation rules apply concurrently with severance runout period.

MILITARY LEAVE

If you are absent from work in order to fulfill a period of duty in the U.S. Uniformed Services, you and your dependents shall be treated as any other qualified beneficiary under COBRA continuation of benefits. (See section "Rights at Termination of Insurance - COBRA".) If your period of military leave is less than 31 days, you will be required to pay the employee share of coverage.

DISABLED EMPLOYEES

If you become totally disabled, and *you are receiving benefits under the Fermilab long term disability plan*, you and your eligible dependents will continue to be covered under the medical plan. Your coverage continues and your dependent's coverage continues if you continue to pay your portion of the required premium.

If after two years of receiving Social Security disability benefits you are still disabled, you must apply for Medicare benefits (Parts A & B) to supplement your group medical coverage. Fermilab's plan will assume that you enrolled in Medicare and will reduce the benefits accordingly when Medicare is the first payor.

A disabled employee who is eligible and elects to retire is treated as a retiree under the medical plan.

HOW TO FILE A CLAIM

Preferred Provider Organization

Claim forms are required for services received from out-of-network providers. The medical claim forms are available from the Benefits Office, 15th floor Wilson Hall, extensions 3395, 4362 or 4361. A claim form must be completed at least once a year per diagnosis. On the Claim Form there is a section to be completed by the employee and the patient (or patient's parent if the patient is a minor). The "Provider Section" on the claim form should be completed by the provider of services (e.g. doctor, hospital, pharmacist etc.) If the provider is unable to complete the Provider Section, you can attach the itemized bill to the claim form. Be sure that the diagnosis is on the provider's bill, and that you have copies of the claim form and bills for your records. Mail the claim form to the claims office address on the form.

The claim form should be completed as soon as you have incurred covered expenses. Claims will be honored up to two years after you have incurred them. Decisions on most claims submitted will be made within 30 days of submission. If the claim is denied, you will receive a written reason for the denial. When a claim is denied, you may have it reviewed by both a Fermilab representative and a Connecticut General claims representative. Determinations will be made in writing within a reasonable period.

Point of Service Plan and HMO Illinois

Claim forms are not required for services received from your primary care doctor. All referrals made by your primary care doctor must be made in writing. If you receive referral bills, contact your plan for instructions.

If you receive out-of-area emergency treatment, you must submit the bills to your plan for payment. You may have to complete a claim form. Contact your plan for instructions.

RETIREE MEDICAL PROGRAM

Who Is Eligible for Retiree Medical Benefits

Starting at age 55 a combination of age and continuous years of service (3 year minimum) must equal 65 before employees and their eligible dependents are eligible for retiree medical benefits. (For example an employee with ten unbroken years of service would be eligible for retiree medical benefits at age 55; with five years of service at age 60.)

Who Is An Eligible Dependent

Your lawful spouse and eligible children enrolled in the medical program at least for three continuous years immediately prior to retirement are eligible to participate in the retiree medical program. (If an employee's spouse was covered at least for three years under another employer's medical plan and not Fermilab's plan immediately prior to the employee's retirement date, that dependent is considered eligible to participate in the retiree medical program. Proof of spouse's other coverage is required at retirement to enroll in the PPO or HMO IL plan. There are no retiree benefits under the Point of Service Plan.

Dependent Coverage In The Event Of Your Death

Dependent retiree medical benefits will continue for your spouse in the event of your death.

Benefits

Preferred Provider Organization

The PPO retiree medical plan is the same as the active employee PPO medical plan. However, at age 65 the plan is designed to supplement Medicare Parts A & B to the level of coverage provided to active employees.

Health Maintenance Organization (HMO IL)

The under age 65 HMO retiree medical benefits are the same as the active employee HMO medical benefits. However, at age 65 the HMO benefits are designed to supplement Medicare Parts A & B, and the benefits may vary from the active employee HMO medical benefits. (Refer to your HMO booklet for details.)

Medicare

When you or your dependent become eligible for Medicare at age 65, you *must* join Medicare Parts A & B. Medicare will be the first payor and Fermilab's plan will be the second payor. There is a substantial reduction in PPO and HMO medical benefits if you fail to join both parts of Medicare. The PPO and the HMO will not pay for medical expenses that Medicare could be paying.

Enrollment

At least two months before you retire make an appointment with the Benefits Office, extension 4361 to complete a Retirement Application. If you are eligible for retiree medical coverage and are enrolled in HMO IL prior to retirement, you can elect to remain in HMO IL or transfer your coverage to the PPO plan. **This is a one-time option. The annual "open enrollment" does not apply to retirees.**

Cost

Employees who retire on or after January 1, 1997 must contribute to the cost of their coverage. The rate retirees contribute for their medical insurance premium was stated on their Fermilab Retirement Application and Summary of Retiree Benefits Memo. Effective January 1, 2002, all employees subsequently selecting early retirement will continue to pay the premium amount agreed upon for active employees following the annual group insurance review. All employees who are 65 years or older and are eligible for Medical coverage and elect the coverage will pay the difference between the annual rate for active employees and the Medicare premium if it exceeds the prevailing Medicare premium. The minimum premium that Medicare eligible retirees will pay for single coverage is $2.50 and for family coverage is $5.34. Premiums for Medicare eligible retirees will be reconsidered every January.

Example: Retiree Monthly Payments

	Active Rate	Retiree Under Age 65	Retiree Age 65 & Over*
PPO			
Single	$41.41	$41.41	$2.50
Family**	$142.31	$142.31	$24.91
Family***	$142.31	$83.61	$83.61
HMO			
Single	$37.14	$37.14	$2.50
Family**	$126.28	$126.28	$8.88
Family***	$126.28	$67.58	$67.58

Medicare rate: $58.70 per individual /Retiree and spouse both on Medicare/***One spouse on Medicare and one spouse non-Medicare*

Termination of Coverage

Medical coverage terminates on the earliest of the following dates:

- The date the plan is discontinued.
- The date premium, if applicable, is not paid.
- The date the retiree ceases to be eligible because of other employment.
- The date the retiree cancels coverage. (Retiree coverage that is declined or cancelled, other than for other coverage, can not be reinstated.)

Other Employment

If an employee retires and becomes re-employed, the retiree will be excluded from Fermilab's retiree medical program if the new employer makes available group medical coverage. Retiree medical coverage can be reinstated upon termination of the other employment. However, reinstatement may not always be the same medical plan in which you were enrolled prior to your other employment. You must notify the Benefits Office within 30 days of termination of the other employment to reinstate Fermilab retiree medical coverage.

How to File A Retiree Medical Claim

Preferred Provider Organization

Retirees & Dependents Under Age 65

Claims are filed exactly the way they were filed when you were an active employee enrolled in the PPO plan. (See section "How To File A Claim.")

Retirees & Dependents Age 65 & Over

Medicare is your first payor. All claims should be submitted to Medicare first. When you receive the Medicare payment voucher or denial, attach a completed PPO claim form and itemized bill to it, and forward the claim to the claims office address on the form. Failure to follow this procedure will delay processing of your claim.

Health Maintenance Organization (HMO IL)

Claim forms are not required for services received from your primary care doctor. All referrals made by your primary care doctor must be made in writing. If you receive referral bills, contact your HMO for instructions. If you receive out-of-area emergency treatment, you must submit the bills to the HMO for payment. You may have to complete a claim form. Contact your HMO for instructions.

GRIEVANCE PROCEDURES - ACTIVE AND RETIRED EMPLOYEES

Following is a brief description of each of the plan's grievance procedures. Refer to your plan's booklet for details. Failure to follow the correct procedure within the time allowed will jeopardize your claim.

All complaints can also be directed to the :

Illinois Insurance Department
Consumer Services Section
320 West Washington
Springfield, Illinois 61767

Preferred Provider Organization

The procedure is described in the ERISA Information Section of this booklet.

CIGNA Point of Service Plan

All inquiries and complaints should be directed to:

Member Relations Department
CIGNA Healthplan of Illinois
1700 Higgins Road
Des Plaines, Illinois 60018
708-699-5671

HMO Illinois

Should HMO Illinois deny your claim, you may have your claim reviewed by writing to:

Director
HMO Illinois
233 North Michigan Avenue, Suite 1625
Chicago, Illinois 60601

ERISA INFORMATION

This section contains a summary description of the following medical plans:

Plan Name	Plan Number
CIGNA Preferred Provider Organization	502
HMO Illinois	509
CIGNA Healthplan (POS)	512

Employer Identification Number

52-0816670

Plan Sponsor

Universities Research Association, Inc.
(Fermi National Accelerator Laboratory)
P.O. Box 500
Batavia, Illinois 60510

Type of Plan

Welfare - Medical

Plan Year Ends

The benefit plan records are kept on a calendar year basis. The plan year ends each December 31.

Plan Administrator

Head, Laboratory Services
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, IL 60510
(630) 840-3396

Plan Fiduciary

Vice President
Universities Research Association, Inc.
Suite 400
1111 19th St. N.W.
Washington, D.C. 20036

Agent For Service of Legal Process

Plan Administrator and/or Plan Fiduciary

Plan Cost

Paid by the employer and employee.

Benefits Provided and Administered By

Connecticut General Life Insurance Company
195 Broadway
New York, NY 10007

HMO Illinois, Inc.
1515 West 22nd Street
Oak Brook, IL 60521-0226

CIGNA Healthplan of Illinois, Inc.
1700 Higgins Road, Suite 600
Des Plaines, IL 60018

Effective Date

PPO Medical Insurance	08/01/67
HMO Illinois	01/01/85
CIGNA Health Plan	10/01/87

Eligibility

All employees and their eligible dependents except dayworkers and summer employees. All retirees and their eligible dependents.

Loss of Benefits

You and your eligible dependents must continue to be a member of an eligible class and continue to make any required contributions. (See termination of coverage section.)

Universities Research Association, Inc. (Fermi National Accelerator Laboratory) maintains the right through the plan administrator to modify, amend or terminate the medical plans described in this booklet.

Collective Bargaining Agreements

Benefit information can be found in the following labor agreements.

Local No. 113, International Association of Machinists (AFL-CIO): Machinist and Welders.

Local No. I-21, International Association of Fire Fighters (AFL-CIO): Fire Fighters.

Local No. 113, International Association of Machinists (AFL-CIO): Computer Operators.

Local No. 113, International Association of Machinists (AFL-CIO): Electricians and Mechanics.

Requests For Information and Claim Procedures

Request for information and claims concerning eligibility, participation, contributions, or other aspect of the operation of any plan should be directed to the Plan Administrator. If a written request or claim is denied, the Administrator shall, within a reasonable time, provide a written denial to the participant. It will include the specific reasons for denial, the provisions of the plan upon which the denial is based, a description of any material needed to complete the claim (if appropriate) and why it is necessary, and instructions on how to apply for a review of the claim. When the Administrator requires additional time to process a claim because of special circumstances, an extension may be obtained by notifying the participant that a decision on the claim will be delayed, what circumstances have caused the delay and when a decision can be expected. The Administrator will inform the participant of the delay within ninety days of the date the claim was submitted.

A participant may request in writing a review of a denied claim and may review pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the participant a decision upon such request for review of a denied claim within sixty days of receipt of the request. When special circumstances require an extension, the Administrator may obtain such extension by notifying the participant that the decision on the review of the denied claim will be delayed, why and when a decision can be expected. See each plan's section for specifics on how to file a claim.

Rights and Protections

The following statement of ERISA rights is required by federal law and regulation. As a participant in the retirement and welfare plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreement and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The Plan Administrator's Office is located at Robert R. Wilson Hall, 15th floor.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator.

3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, your union or any other person, may fire you

or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension & Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210.

Life and Accident Plans

INTRODUCTION

One of the major policies of Universities Research Association, Inc. and Fermi National Accelerator Laboratory is to provide a comprehensive program of benefits for its employees. Included in the benefit program are life and accident plans that provide valuable financial protection for you and your family in the event of death. Insurance protection to help cushion against the hardship that can accompany death is important to all of us, and Fermilab has made this protection available to you by providing the following group plans:

- Basic & Supplemental Life Insurance
- Dependent Life Insurance
- Accidental Death & Dismemberment Insurance
- Business Travel Accident Insurance

Fermilab pays the full cost of your Group Basic Life Insurance, Accidental Death and Dismemberment Insurance and Business Travel Accident Insurance. You can elect to enroll in the Group Supplemental Life Insurance and the Dependent Life Insurance programs, and you will pay the full cost.

Please read the following pages carefully. If by chance, the information in this booklet conflicts with the insurance contracts, your rights to benefits will be determined under the terms of the insurance contracts.

GROUP LIFE INSURANCE

(Connecticut General Life Insurance Company)

Schedule of Benefits to Age 65

Basic Life:	An amount equal to one times your annual basic earnings.
Supplemental Life I:	An amount equal to one times your annual basic earnings.
Supplemental Life II:	An amount equal to two times your annual basic earnings.
Combined Maximum:	The sum of your Basic and Supplemental Life Insurance may not exceed $300,000.

(The life insurance amounts will be rounded to the nearer $1,000, if not already a multiple of $1,000).

Example:	Employee 1	Employee 2	Employee 3
Earnings:	$32,300	$32,300	$32,300
Elects:	Basic	Supp. I	Supp. II
Coverage:	$32,000 Basic	$32,000 Basic	$32,000 Basic
		$32,000 Supp I	$65,000 Supp II
Total:	*$32,000*	*$64,000*	*$97,000*

Schedule of Benefits from Age 65 to 70

65 92% of the combined amount of your life insurance
66 84% of the combined amount of your life insurance
67 76% of the combined amount of your life insurance
68 68% of the combined amount of your life insurance
69 60% of the combined amount of your life insurance
70+ 60% of the combined amount of your life insurance or $45,000, whichever is the lesser.

Example:	Employee 1	Employee 2	Employee 3
Amount pre-65	$32,000	$64,000	$97,000
65	$29,440	$58,880	$89,240
66	$26,880	$53,760	$81,480
67	$24,320	$48,640	$73,720
68	$21,760	$43,520	$65,960
69	$19,200	$38,400	$58,200
70 and over	$19,200	$38,400	$45,000

Who is Eligible

All employees except dayworkers and summer employees are eligible to enroll for coverage as of the first day of employment.

Enrollment

At the employee orientation meeting on the first day of employment you are enrolled for the Basic coverage, and you can elect the Supplemental coverage at that time or within 30 days of employment. If you elect Supplemental coverage after the first 30 days of employment, you will be required to submit a statement of your physical condition which must be approved by Connecticut General Life Insurance Company.

Effective Date of Your Coverage

Your coverage will become effective on the day that you enroll, but no earlier than the day you become eligible. If you enroll after the first 30 days of employment, your coverage will not be effective until Connecticut General agrees in writing to insure you.

Cost

The Basic coverage is provided at no cost to you. The Supplemental 1 coverage cost is $.15 per $1,000 of coverage per month. The Supplemental 2 coverage cost is $.16 per $1,000 of coverage per month. For your convenience, the cost is deducted from your paycheck. (There is a temporary suspension of the payroll deduction.)While the temporary supsension is in place, this benefit is open only to new employees during the first 30 days of employment at the Laboratory.

Example Coverage:	Employee 1	Employee 2	Employee 3
Basic	$32,000	$32,000	$32,000
Supp. I	0	$32,000	0
Supp. II	0	0	$64,000
Supp. cost per mo.	0	$4.80	$9.92

Beneficiary

When you enroll in the life insurance program, you should name a beneficiary to receive the loss of life benefit. You may change your beneficiary at any time by completing a change form which is available from Fermilab's Benefits Office. No change will take effect until this form is signed and dated by you. If you die before the change form is received by Fermilab's Benefits Office, Connecticut General and URA/Fermilab will not be liable for any payment it has already made.

Payment of Benefits

In the event of your death from any cause, life insurance benefits in the amount for which you enrolled will be paid to your designated beneficiary(ies). Payment will be made in one lump sum unless installment payments are requested.

Termination of Coverage

Your Basic Life Insurance and Supplemental Life Insurance coverages end on the earliest date below:

- date you cease to be in an eligible class,
- date you cease to pay the required contribution,
- date your employment terminates (In the case of approved leave of absence and disability your coverage may continue.), or
- date the policy is cancelled.

When your coverage terminates, you may have the right to convert the group insurance to an individual policy. Refer to the section on conversion rules.

Leave of Absence

You may continue your life insurance coverage from the date of your approved leave of absence. You will have to pay the cost of the Basic coverage, as well as any Supplemental coverage in which you may be enrolled. You must contact the Benefits Office to make the arrangements for payment.

Layoff

Your life insurance coverage ends on your last working day. If you are eligible for severance and if the runout pay out period option under the severance plan is an option available to you, your life insurance will continue to the end of the payout period as long as premiums are paid.

Basic Life Coverage During Total Disability

As long as you qualify for long term disability benefits under the Long Term Disability plan, your Basic Life Insurance premium will continue to be paid by Fermilab. (This applies to employees disabled on or after February 1, 1988.)

Supplemental Life Coverage During Total Disability

If you qualify for long term disability under the LTD plan and become disabled prior to age 60, you may file for a waiver of the Supplemental Life premium with Connecticut General after nine months of disability. If Connecticut General approves, your Supplemental Life Insurance will continue for one year at no cost to you. Subsequent proof of total disability must be furnished to Connecticut General every 12 months to continue the waiver of premium. If you do not receive approval from Connecticut General, your Supplemental Life Insurance will terminate. However, you have the right to convert it to an individual policy according to the conversion rules of the insurance policy.

You are not eligible to file for a waiver of the Supplemental Life premium if you become disabled on or after your 60th birthday. Your Supplemental Life coverage will terminate. However, you can convert it to an individual policy according to the conversion rules of the insurance policy.

Conversion Rules

Your are entitled to convert your Life Insurance only if:

- your insurance ceases because you are no longer in active service or no longer eligible for life insurance,
- your insurance is reduced because of age, or
- the policy is cancelled for your class of employees and you have been insured under the policy for at least five years before it is cancelled.

The amount of life insurance that you are entitled to convert is normally the amount of group life insurance that you lose, but in some cases, it may be less. A brochure describing the details of the converted policy may be obtained from the Benefits Office.

Payment During Conversion Period

If you die during the 31 days in which you may convert to an individual life policy, Connecticut General will pay to the beneficiary(ies) designated under your group policy, the amount of insurance that you could have converted.

How to File a Claim

If there is a claim covered by Connecticut General Group Life Insurance, the Benefits Office will complete the claim form and submit it to Connecticut General for settlement.

The Benefits Office, 630-840-4361 or 630-840-3395, located on the 15th floor, west side, of Wilson Hall, should be notified as soon as possible. A certified copy of the death certificate is required to submit a claim.

IRS Policy on Group Term Life Insurance

The Internal Revenue Service rules that anyone participating in group term life insurance plans (such as Fermilab's Connecticut General plan) must pay a tax on the amount of life insurance above $50,000.00. The tax is dependent upon the age of the participant on the last day of his or her tax year. The employee contributions to the cost of the insurance reduces the taxable amount. The taxes effective July 1, 1999 are as follows:

IRS Table 1: Cost per $1,000 of Coverage per Month

Age	Cost
Under 25	$.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.66
65-69	1.27
70 & over	2.06

As of January 1, 1988, the value of group term life insurance in excess of $50,000 is also subject to FICA (Social Security tax). The value is determined by using IRS Table 1.

Example:	**Employee 1**	**Employee 2**	**Employee 3**
Age:	56	56	56
Basic Life Ins.	$50,000	$50,000	$50,000
Supp. I	0	$50,000	0
Supp. II	0	0	$100,000
Total Life Ins.	$50,000	$100,000	$150,000
Non-taxable Life Ins.	$50,000	$50,000	$50,000
Taxable Life Ins.	0	$50,000	$100,000
Table 1 Rate	$0.43	$0.43	$0.43
Annual Table Cost	0	$258.00	$516.00
Employee Cost of Suppl Life Ins.	0	$234.00	$468.00
Taxable Income	0	$24.00	$48.00
Employer Social Security Tax (7.65%)	0	$1.84	$3.67
Employee Social Security Tax (7.65%)	0	$1.84	$3.67

GROUP DEPENDENT LIFE INSURANCE

(Connecticut General Life Insurance Company)

Schedule of Benefits

	Option A	or	**Option B**
Spouse	$5,000		$10,000
Children			
15 days but less than 6 mos	$200		$400
6 mos. but less than 21 yrs.	$2,000		$4,000

Who is Eligible

Employees enrolled in the Connecticut General Supplemental Life Insurance program are eligible to enroll their family for Dependent Life Insurance as of the first day of employment or as of the first day the employee acquires dependents (e.g. marriage, newborn).

Enrollment

You have 30 days from the first day of employment or 30 days from the day you acquire your dependent to enroll for Dependent Life Insurance. If you elect the coverage after the 30 day period, you will be required to submit

evidence of your dependent's good health which must be approved by Connecticut General.

Definition of Dependent

For purposes of this coverage, the term "dependent" means:

- your lawful spouse, and
- your children over 14 days of age but under 21 years and unmarried.

Any individual qualifying as an employee cannot be covered as a dependent.

The term children includes children born of you, children legally adopted by you and stepchildren living with you in a normal parent-child relationship.

Effective Date of Coverage

Your dependent's coverage will be effective on the day that you enroll them, but no earlier than the day they become eligible. If you enroll your dependents after the 30 day period, their coverage will not be effective until Connecticut General agrees in writing to insure them.

Cost

Your monthly premium is $.64 for Option A and $1.27 for Option B regardless of the number of dependents.

Beneficiary

The employee is automatically the beneficiary for the dependent's life insurance.

Payment of Benefits

In the event of a dependent's death, life insurance benefits in the amount for which he/she was enrolled will be paid to the employee in a single sum.

Termination of Coverage

Your Dependent Life Insurance coverage ends on the earliest date below:

- date you cease to be in an eligible class,
- date you cease to pay the required contribution,
- date you cease to carry Supplemental life coverage,
- date your dependent is no longer eligible (It is your responsibility to notify the Benefits Office to stop the payroll deduction when you no longer have eligible dependents. Failure to notify will not result in a refund of deductions),
- date your employment terminates (In the case of approved leave of absence and disability, Dependent life coverage may be continued. Refer to the sections on "Leave of Absence" and "Coverage While You Are Disabled"), and
- date the policy is cancelled.

When Dependent Life coverage terminates, your dependents may have the right to convert the group insurance to an individual policy. Refer to the section in this booklet on conversion rules.

Leave of Absence

You may continue your Dependent Life coverage provided that you continue your Connecticut General Supplemental Life Insurance coverage from the date of your approved leave of absence. You must contact the Benefits Office to make the arrangements for payment.

Lay Off

Your dependent's life insurance coverage ends on your last working day. If you are eligible for severance and if the runout payout option under the severance plan is an option available to you, your dependent's life insurance will continue to the end of the payout period as long as you continue supplemental life insurance and premiums are paid.

Coverage While You Are Disabled

As long as your Connecticut General Supplemental Life Insurance is enforce, you can continue to pay for Dependent Life Insurance. You must contact the Benefits Office to make the arrangements for payment.

Employee's Life Insurance Reduction Between Age 65 and 70

If the employee's basic and supplemental life insurance reduction between age 65 and 70 eliminates the supplemental coverage, the employee can continue dependent life insurance.

Conversion Rules

A dependent is entitled to convert the Group Life Insurance to an Individual policy only if the dependent's insurance stops because:

- you are no longer in active service or no longer eligible for Dependent Life Insurance,
- you die,

- coverage cancelled for your class of employees and your dependent has been insured under the policy for at least five years before the insurance cancelled, or
- your dependent no longer qualifies as a dependent.

The amount of life insurance to be converted is normally the amount of group life insurance that your dependent looses, but in some cases, it may be less. A brochure describing the details of the converted policy may be obtained from the Benefits Office.

Payment During Conversion Period

If the dependent dies during the 31 day conversion period, Connecticut General will pay to the beneficiary the amount of insurance that could have been converted.

How to File a Claim

If there is a claim covered by Connecticut General Group Life Insurance, the Benefits Office will complete the claim form and submit it to Connecticut General for settlement. The Benefits Office, 630-840-4361 or 630-840-3395, located on the 15th floor, west side, of Wilson Hall, should be notified as soon as possible. A certified copy of the death certificate is required to submit a claim

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ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
(Connecticut General Life Insurance Company)

Schedule of Benefits

Annual Basic Earnings	Amount of Principle Sum
Up to $2,499	$2,500
$2,500 to $4,999	$5,000
$5,000 to $7,499	$7,500
$7,500 to $9,999	$10,000
$10,000 and over	$12,500

Table of Losses and Benefits

	% of Principle Sum
Loss of Life	100%
Loss of One Hand by Severance at or above the Wrist	50%
Loss of One Foot by Severance at or above the Ankle	50%
Entire and Irrecoverable Loss of Sight in One Eye	50%
Loss of more than one of the above in an Accident	100%

Who is Eligible

All employees except dayworkers, summer employees and employees on leave of absence.

Enrollment

At the time you enroll for the Basic Life Insurance, you are automatically enrolled for AD&D insurance.

Effective Date of Your Coverage

Your coverage will be effective on the same day as your Basic Life Insurance.

Cost

The cost of AD&D Insurance is paid in full by Fermilab..

Beneficiary

In the event of accidental death covered under the policy, your beneficiary will be the person or persons designated under your Basic Life Insurance.

Payment of Benefits

Connecticut General will pay the benefit amount when they receive proof that you received an accidental bodily injury while you were insured, and that the loss occurred within 90 days after the date of the injury.

The benefit amount for each loss will be the amount of your principal sum multiplied by the percentage shown in the Table of Losses and Benefits for that loss. The maximum that will be paid for all losses resulting from injuries you receive in any one accident will be your principal sum.

Exclusions

AD&D Insurance does not cover losses that occur more than 90 days after the accident, nor any loss resulting from war, suicide, intentionally self-inflicted injury while sane or insane, ptomaine poisoning, bacterial infection (except pus-forming infection resulting from an accidental wound), and losses due to disease.

Termination of Coverage

Your AD&D Insurance ends on the earliest date below:

- date you cease to be in an eligible class,
- date your employment terminates,
- date the policy is cancelled, or
- date premium stops.

How to File a Claim

If there is a claim covered by Connecticut General Group Life Insurance, the Benefits Office will complete the claim form and submit it to Connecticut General for settlement. The Benefits Office, 708-840-4361 or 708-840-3395, located on the 15th floor, west side, of Wilson Hall, should be notified as soon as possible. Filing a death claim requires a certified copy of the death certificate

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BUSINESS TRAVEL ACCIDENT
(CHUBB Group of Insurance Companies)

Schedule of Benefits

Class I	The Principal sum is five times annual salary subject to a $50,000 minimum and a maximum of $300,000. Medical evacuation and repatriation maximum is $50,000. Felonious assault is $25,000.
Class II	$300,000 Medical evacuation and repatriation maximum is $50,000. Felonious assault is $25,000.

Family Coverage

Spouse	$50,000
Children	$25,000

Aggregate limit per accident - $1,500,000

Annual salary means the salary received by the employee from URA not including any overtime earnings and bonuses.

The plan shall pay an amount determined from the table of losses if an insured person sustains a loss within 365 days after the accident.

Table of Losses and Benefits

Loss	Percent of Loss of Life Benefit Amount
Life	100%
Speech and hearing	100%
Speech and one of: hand, foot or sight of one eye	100%
Hearing and one of: hand, foot or sight of one eye	100%
Both hands, both feet or sight of both eyes or a combination of a hand, a foot or sight of one eye	100%
One hand or one foot or sight of one eye	50%
Speech or hearing	50%
Thumb and index finger of the same hand	25%
Psychological therary	1%
Rehabilitation/Retraining	1%

The term **loss** with regard to hands and feet shall mean actual severance through or above the wrist or ankle joints; with regard to eyes, entire irrecoverable loss of sight; with regard to speech, irrecoverable loss of speech which does not allow audible communication in any degree; with regard to hearing, the entire and irrecoverable loss of hearing as determined by a physician; and with regard to thumb and index finger actual severance through or above the melacarpophalangeal joints.

Loss of Use	Percent of Loss of Life Benefit Amount
Both arms and both legs	100%
Both arms or both legs or a combination of an arm and a leg	75%
One arm or one leg	50%
Both hands or both feet or a combination of a hand and a foot	50%
One hand or one foot	25%

The term **loss of use** means the permanent and total inability of the specified body part to function as determined by a physician and approved by the company. Loss of use of an arm means the loss of use at or above the elbow joint; a foot means the loss of use at or above the ankle joint; a hand means loss of use at or above the knuckle joints of at least four fingers on the same hand or at least three fingers and a thumb on the same hand; a leg means loss of use at or above the knee joint.

Coverage

The policy provides full 24-hour accident coverage while you are traveling on a business trip. Coverage begins at the actual start of an anticipated trip, whether it be from the Laboratory site, your home or other location, whichever occurs last.

In the case of combined business/vacation trip, you will have 24-hour accident coverage traveling to and from the destination plus the designated time of the business meeting. You will not be covered during any period that would be designated as vacation time.

Travel coverage also includes short business travel, for example, going to the hardware store: from the time you go off site until the time you return to the site.

If you are traveling with other URA employees, URA directors and trustees, members of the Users Executive Committee and URA consultants, the benefits may differ from the Schedule of Benefits because of the $1,500,000

aggregate limit. If you are traveling in a group comprised of the above persons, contact the Benefits Office to make sure that the group does not exceed the aggregate limit.

Permanent Total Disability

Should you become totally and permanently disabled prior to age 70 within 12 months of a business travel accident, remain disabled for twelve consecutive months and unable to work, the principal sum less any other amount paid or payable under the accidental death and dismemberment indemnity coverage of this policy will be paid to you. The policy also provides coverage, subject to the policy maximum, for a loss caused by or resulting from accidental bodily injuries sustained by an insured person as a result of an act of violence, which occurs while the insured person is on the premises of the policyholder.

Seat Belts

An additional 10% of the principal sum amount up to a maximum of $50,000 will be paid if the insured person suffers loss of life despite restraint by a seat belt in a covered automobile accident.

Disappearance

If the body of an insured person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it will be assumed that the person died and payment of benefits will be made according to the terms and conditions of the policy.

Emergency Medical Evacuation

This means the emergency transportation of the insured person from the location where the insured person is injured or becomes ill to the nearest hospital where appropriate medical treatment can be obtained.

Repatriation

This means the transfer of the insured person from the local hospital where the emergency medical care is initially given to the insured person's country of domicile or to the insured person's residence to obtain further medical treatment or to recover.

Repatriation also means the necessary arrangements for the return of the insured person's remains to the insured person's place of residence in the event of the injured person's loss of life.

Travel Assistance Services

In the event of a travel-related emergency, MEDEX Traveler's Assistance Network will provide emergency assistance services for: replacing lost or stolen travel documents, including passports; emergency fund transfers; locating the nearest, most appropriate medical care; establishing contact with family, personal physician and employer; translation services and referral to local interpreters and knowledgeable legal referral; and incidental aid and other travel-related services. For more information about services provided by the MEDEX Assistance Corporation consult their brochure available from Fermilab's Benefits Office and Fermilab's Travel Office.

Who is Eligible

Class I	All employees of Universities Research Association, Inc.
Class II	All non-employee directors, the trustees, members of Fermi National Accelerator Laboratory Users Executive Committee and all consultants of URA.

Family coverage applies when the legal spouse and dependent children travel with the employee in conjunction with an authorized business trip or relocation. (See the master policy for definition of dependent child and relocation.)

Effective Date of Your Coverage

You are automatically covered as of the first day of work.

Cost

URA pays the full cost.

Beneficiary

In the event of accidental death covered by this policy, your benificiary(ies) will be the person or persons designated under your Basic Group Life Insurance policy, unless you with to designate a specific beneficiary for this insurance

You can obtain the beneficiary form from the Benefits Office.

Termination of Coverage

Your Business Travel Accident Insurance ends on the earliest date below:

- date you cease to be in an eligible class,
- date your employment terminates, or
- date the policy is cancelled.

How to File a Claim

If there is a claim covered by the travel accident policy, the Benefits Office will submit the claim form to CHUBB Group of Insurance Companies for settlement. When the claim is for accidental death, a certified copy of the death certificate is required. Decisions on most claims submitted will be made within 30 days of the date submitted.

Exclusions

This insurance does not apply to an accident occurring while an insured person is in, entering or exiting an aircraft owned, leased or operated by URA or an aircraft owned, leased or operated by an employee of URA. This exclusion does not apply to aircraft chartered with pilot or crew on a one time charter basis.

This insurance does not apply to an accident occurring while an insured person is in, entering or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

This insurance does not apply to loss caused by or resulting from an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, or bodily malfunctions. This exclusion does not apply to loss resulting from an insured person's bacterial infection caused by an accident or from accidental consumption of a substance contaminated by bacteria.

This insurance does not apply to suicide, attempted suicide or loss that is intentionally self-inflicted.

This insurance does not apply to loss caused by or resulting from a declared or undeclared war. Declared or undeclared war does not include acts of terrorism.

This insurance does not apply to an accident occurring while an insured person is participating in military action in the armed forces of any country or established international authority. However, orders to active military service for sixty consecutive days or less shall not constitute service in the armed forces

This insurance does not provide coverage in Afghanistan, Pakistan, Iran, Iraq, Syria and Israel. The list of prohibited countries or territories can change. Contact Fermilab's Benefits Office if you have any questions regarding your business travel plans outside the USA.

ERISA INFORMATION

Plan	Plan Number
Group Life Insurance	501
Accidental Death & Dismemberment Insurance	503
Business Travel Accident Insurance	505

Employer Identification Number

52-0816670

Plan Sponsor

Universities Research Association, Inc.
(Fermi National Accelerator Laboratory)

Type of Plan

Welfare

Plan Year Ends

The benefit plan records are kept on a calendar year basis. The plan year ends December 31.

Plan Administrator

Head, Laboratory Services
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, Il. 60510
630-840-3396

Plan Fiduciary

Vice President
Universities Research Association, Inc.
1111 19th Street N.W.
Suite 400
Washington, DC. 20036

Agent for Service of Legal Process

Head, Laboratory Services
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, IL 60510
630-840-3396

Vice President
Universities Research Association, Inc.
1111 19th Street N.W.
Suite 400
Washington, D.C. 20036

Plan Cost

Paid by the employer and employees.

Benefits Underwritten By

Group Life, AD&D and Dependent Life Insurance
Connecticut General
220 E. 42nd Street
New York, New York 10017

Business Travel Accident Insurance
Federal Insurance Company
Sears Tower, Suite 4700
233 South Wacker Dr.
Chicago, IL 60606-6303

Effective Date

Group Life, AD&D, Dependent Life Insurance	8/1/67
Business Travel Accident Insurance	8/1/68

Eligibility

See eligibility section of each plan for details.

Loss of Benefits

You must continue to be a member of the class to which these plans pertain and continue to make any of the contributions agreed to when you enrolled. See each plan in this booklet for additional conditions that may cause you the loss of benefits.

URA/Fermilab maintains the right through the Plan Administrator to modify, amend or terminate one or all of the plans described in this booklet

Collective Bargaining Agreements

Local No. 701, International Association of Machinists (AFL-CIO): Machinists and Welders

Local No. I-21, International Association of Fire Fighters (AFL-CIO): Fire Fighters

Local No. 701, International Association of Machinists (AFL-CIO): Computer Operators

Local No. 701, International Association of Machinists (AFL-CIO): Maintenance Electricians and Mechanics

Requests for Information and Claim Procedures

Requests for information and claims concerning eligibility, participation, contributions or other aspects of the operation of any plan should be directed to the Plan Administrator. If a written request or claim is denied, the Administrator shall, within a reasonable time, provide a written denial to the participant. It will include the specific reasons for denial, the provisions of the plan upon which the denial is based, a description of any material needed to complete the claim (if appropriate) and why it is necessary, and instructions on how to apply for a review of the claim. When the Administrator requires additional time to process a claim because of special circumstances, an extension may be obtained by notifying the participant that a decision on the claim will be delayed, what circumstances have caused the delay and when a decision can be expected. The Administrator will inform the participant of the delay within ninety days of the date the claim was submitted.

A participant may request in writing a review of a denied claim and may review pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the participant

a decision upon such request for review of a denied claim within sixty days of receipt of the request. When special circumstances require an extension, the Administrator may obtain such extension by notifying the participant that the decision on the review of the denied claim will be delayed, why, and when a decision can be expected.

See each plan's section for specifics on how to file a claim.

Rights and Protections

The following statement of ERISA rights is required by federal law and regulation. As a participant in the retirement and welfare plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The Plan Administrator's Office is located at Robert R. Wilson Hall, 15th floor.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator.

3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Long Term Disability Insurance

INTRODUCTION

One of the major objectives of Universities Research Association, Inc./ Fermi National Accelerator Laboratory is to provide and maintain a comprehensive program of benefits for its employees. Fermilab has arranged with Life Insurance Company of North America, a CIGNA company, to include a Long Term Disability plan in the Laboratory's benefit program. The Long Term Disability plan provides continuation of a part of your income during a prolonged disability.

Fermilab and you share in the cost of the Long Term Disability coverage. After six month of employment your required contribution will automatically be deducted from your paycheck provided that you are eligible to participate in this plan.

This kind of insurance can be very important, if you need it, for lengthy disabilities can quickly exhaust your savings. This summary represents general information only regarding the terms of the plan. While every effort has been made to make this summary as accurate as possible, if there are any inconsistencies between this summary and the provisions of the insurance policy, the insurance policy shall govern. The benefits and other principal provisions described in the summary are effective only is you are eligible to participate, become a participant and remain a participant in accordance with the provisions of the plan.

No person has the authority to make any verbal statement on any kind at any time which is legally binding upon Universities Research Association, Inc.

It is the intent of URA to provide a Long Term Disability plan as described in this summary. However, they reserve the right through the plan administrator to change or terminate the plan.

SCHEDULE OF BENEFITS

Benefits Start

After 180 continuous days of total disability.

Amount Payable

60% of basic monthly salary as of the date of total disability. Basic monthly salary excludes commissions, bonuses, overtime and other extra compensation.

Maximum Benefit

$12,000.00 per month. See insurance certificate for details.

Minimum Benefit

$100.00 per month.

Payment Period

Determined by your age on the date of disability.

Age at Disability	Maximum Benefit Period
62 or younger	to age 65*
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

*Or the date the 42nd monthly benefit is payable, if later.

Preexisting Condition Exclusion

See insurance certificate for details.

Survivor Benefit Amount

A lump sum equal to 3 times the LTD monthly income benefit.

Pension Contribution Benefit

10% of basic monthly salary, to a maximum of $2,500, as of the date of disability.

Indexed Covered Earnings

Lessor of 10% or increase in the CPI-W.

ELIGIBILITY

All regular full-time employees and full-time employees with scientific term appointments are required to participate in this plan after 6 months of continuous active employment.

ENROLLMENT

There are no enrollment forms to complete. You are automatically enrolled in the plan after 6 months of continuous active service.

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective on the date you complete

6 months of continuous active employment. If you are absent on that date, the effective date of coverage will be deferred until the date you complete one day of work.

COST

Your share of the premium is .3978% of your basic monthly salary to a maximum of $79.56 per month.

TOTAL DISABILITY

You are considered disabled if, solely because of injury or sickness, you are either:

1. unable to perform all the material duties of your regular occupation or qualified alternative
2. unable to earn 80% or more of your indexed covered earnings

After disability benefits have been payable for 24 months, you are considered disabled if, solely due to injury or sickness, you are either:

1. unable to perform all the material duties of any occupation for which you are, or may reasonably become qualified based on education, training or experience
2. unable to earn 80% or more of your indexed covered earnings

WAITING PERIOD

You qualify for long term disability income after you have been totally disabled for 180 continuous days. If you return to work during the waiting period, it must be for a no more than 14 consecutive days or a new waiting period must begin.

During the waiting period your accrued sick leave and vacation should provide an income. If your earned accruals do not cover the waiting period, you will not have income until LTD benefits are approved.

SUCCESSIVE DISABILITIES

If your monthly benefits stop because of your return to work, and while insured, you again become totally disabled because of an injury or sickness which is the same as or related to the previous injury or sickness, and your return to work is for less than 6 months, monthly benefits will resume as though the new period of disability was a continuation of a prior period of disability. Otherwise, you must establish a new 180 day waiting period before benefits will start. (See insurance certificate for details.)

EXCLUSIONS

Payments will not be made under this plan for any disability which directly results from:

1. suicide, attempted suicide or self-inflicted injury while sane and insane
2. war or any act of war, whether or not declared
3. terrorism or active participation in a riot
4. injury or sickness while you are serving on full-time duty in any armed forces
5. commission of a felony
6. the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or sickness otherwise covered by the policy

In addition, disability benefits will not be paid for any period of disability during which you are incarcerated in a penal or corrections institution.

PAYMENT OF BENEFITS

Your disability income is equal to 60% of your basic monthly salary up to the maximum amount in the schedule of benefits. Your disability income will be reduced by any other disability benefits payable under:

- Workers compensation
- Single and family Social Security
- Retirement or unemployment benefits provided under state of federal laws
- Disability or retirement benefits under any other plan of insurance provided by URA
- Damages or settlements recovered in a third party action
- Earnings to the extent provided under the Work Incentive Benefit Calculation

See the insurance certificate for details regarding the Work Incentive Benefits Calculation and any other offsets.

INDEXED COVERED EARNINGS

For the first 12 months Monthly Benefits are payable, your Indexed Covered Earnings are equal to your Covered Earnings. After 12 Monthly Benefits are payable, your Indexed Covered Earnings are your Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits become payable. The amount of each increase will be the lesser of:

1. 10% of your Indexed Covered Earnings during your preceding year of disability or

2. The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year

SOCIAL SECURITY FREEZE

The LTD benefit will be calculated on the basis of the applicable Social Security tables at the time you start to receive monthly income benefits from Social Security and life Insurance Company of North America. Future general increases in Social Security will not decrease Life Insurance Company of North America LTD income benefits.

SURVIVOR BENEFIT

If you die while receiving monthly LTD benefits, Life Insurance Company of North America will pay a survivor benefit equal to 3 times the LTD monthly income benefit. The survivor benefit will be paid to your legal spouse as defined by the state of residence. If there is no surviving spouse, the survivor benefit will be paid to your estate if you have surviving unmarried children under age 21. Survivor benefits will not be paid if there is no eligible spouse or children, and survivor benefits will first be applied to reduce any claim overpayments.

WAIVER OF LTD PREMIUM

The insurance company will waive the cost of the Long Term Disability insurance while you qualify for benefits.

REINSTATEMENT OF INSURANCE

Your coverage may be reinstated if your insurance ends because you are on an Employer approved unpaid leave of absence. Your insurance may be reinstated only if reinstatement occurs within 12 weeks from the date it ends due to an Employer approved unpaid leave of absence. For your insurance to be reinstated the following conditions must be met:

1. You must qualify under the Class Definition.

2. The required premium must be paid.

3. A written request for reinstatement must be received by the insurer within 31 days from the date you returned to Active Service.

Your reinstatement insurance is effective on the date you return to Active Service. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation (if any) before your insurance ended due to an unpaid leave of absence, you will receive credit for any time that was satisfied.

TERMINATION OF LTD INSURANCE

Your LTD insurance will terminate on the earliest date:

- the date you are eligible for coverage under a plan intended to replace this coverage
- the date the policy is terminated
- the date you are no longer in an eligible class
- the day after the end of the period for which premiums are paid
- the date you are no longer in active service
- the date benefits ends because you did not comply with the terms and conditions of the insurance coverage.

If you are receiving disability benefits when the policy terminates, disability benefits will continue if you remain disabled and meet the requirements for the insurance. Any later period of disability, regardless of cause, that begins when you are eligible under another disability coverage provided by any employer, will not be covered.

Termination of the policy for any reason will have no effect on Life Insurance Company of North America's liability under this provision.

EMPLOYMENT STATUS WHILE ON SICK LEAVE PRIOR TO RECEIVING LTD BENEFITS

You will return to the same position if you are released to work within the six months.

EMPLOYMENT STATUS WHILE RECEIVING LTD BENEFITS

If you return within the first six months from the date you are approved for LTD, you will return to your own position or an equivalent position. If, due to medical restrictions, you cannot return to your position or an equivalent one, every effort will be made to find an appropriate position within your Division/Section.

If you return from the seventh month to a year of being on LTD, you will be given priority consideration for existing openings for which you are qualified. These openings can be in any Division/Section at the Lab. No guarantee is made that a position will be found for you.

When you are on LTD for a year, you are placed on inactive status. This means that you are separated from the Lab. If you are able to return to work at this point, you must apply for posted job openings and go through the interview process.

HOW TO FILE A CLAIM

If you have been unable to work because of an injury or sickness for 3 continuous months, contact Fermilab's Benefits Office. The staff will counsel you as to what must be done in order to receive benefits.

Contact: *Employee Benefits Office*
Phone: *(630) 840-4362 or 4361*
Location: *Wilson Hall, 15th Floor*
Address: *P.O. Box 500*
Mail Stop 126
Batavia, IL 60510

You must apply for social security disability benefits. Social Security has a 5 month waiting period. After 3 months of continuous disability call your nearest Social Security Office and apply for benefits.

NOTICE OF COMPLAINT

Complaints regarding Life Insurance Company of North America can be filed with the Illinois Insurance Department at the following address:

Illinois Department of Insurance
320 West Washington St.
4th Floor
Springfield, IL 62767
(217) 782-4515

PENSION AND OTHER BENEFITS WHILE ON LTD

Outline for Employee and Family Coverage (if applicable)

Pension Plan	Contributions continue
Voluntary Pension Plan	Contributions stop
Medical Plan	Employee pays current deduction
Dental Plan	Employee pays current deduction
Basic Group Life Insurance	Continues at no cost
Supplemental Life Insurance	May continue under waiver of premium
Dependent Life Insurance	May continue
Individual Life Insurance	May continue
Long Term Care Insurance	May continue
Auto/Homeowners Insurance	May continue

PENSION PLAN

If you were a participant in the Retirement Plan for Employees of Universities Research Association, Inc. at the time you became totally disabled, the Laboratory's monthly contribution will continue as long as you receive long term disability income. However, it you elect to retire, pension contributions stop. Contributions into your pension fund are based upon your basic monthly salary at the time you become totally disabled. Any voluntary contributions will stop when LTD income benefits start.

MEDICAL PLAN

Employee Coverage

Your medical insurance will continue provided you continue to make the required payments for single

coverage. You will be covered by the plan in which you were enrolled at the time you became totally disabled. While you are totally disabled, you are eligible to change plans during the open enrollment period. If you are eligible to retire and elect to retire, you will be covered under the terms and conditions of the retiree medical plan. Otherwise, coverage terminates when you no longer qualify for LTD benefits.

Dependent Coverage

As long as you qualify for long term disability benefits, your dependents are eligible to continue on the medical plan provided that you make the required payments for family coverage, and they remain eligible dependents under the medical plan in which you are enrolled. If you are eligible to retire and elect to retire, your eligible dependents' will be covered under the terms and conditions of the retiree medical plan. Otherwise, coverage terminates when you no longer qualify for LTD benefits.

Effects of Medicare

If you qualify for Medicare health insurance because of your disability, you must enroll in Medicare Part A and B. Medicare will be the primary payer as long as you continue to be no longer actively at work and continue to qualify for Medicare. However, if you disability is due to renal dialysis, Medicare will be the second pay during the first 18 months of renal treatment, and first payer thereafter.

DENTAL PLAN

Employee Coverage

Your dental coverage will continue as long as you make the required payments. While you are totally disabled, you are eligible to change plans during the open enrollment period. Dental coverage terminates when you retire or no longer qualify for LTD benefits.

Dependent Coverage

Your dependents are eligible to continue on the dental plan provided that you make the required payments for family coverage, and they remain eligible dependents under the plan in which you are enrolled. Dental coverage terminates when you retire or no longer qualify for LTD benefits.

LIFE INSURANCE

Basic Life Insurance

The Laboratory will continue to pay for your group basic life insurance coverage. Basic coverage stops at retirement, termination of LTD benefits or the Laboratory stops paying premiums which ever occurs first.

Supplemental Life Insurance

Employees enrolled in the group supplemental life insurance plan who become totally disabled prior to age 60 can continue to pay the supplemental life insurance premium, and after nine months of total disability can file with the group insurance carrier for a waive of the life insurance premium. When the waiver of premium claim is approved, your supplemental life insurance will continue for one year at no cost to you. Subsequent proof of your total disability must be furnished every twelve months to continue the coverage under the waiver of premium provision. Extension stops at retirement or termination of LTD benefits.

Your group supplemental life insurance coverage will terminate should the insurance carrier not approve your waiver of premium claim. At that time you can convert your group supplement life insurance to an individual conversion policy. (See conversion rules in the life insurance certificate.)

Dependent Life Insurance

If your group supplemental life insurance is continued, your group dependent life insurance can also be continued provided that you pay the required premium, and your dependents are eligible.

If your group supplemental life insurance terminates, your group dependent life insurance will also terminate. However, your dependents can convert their life insurance to an individual conversion policy. (See conversion rules in the life insurance certificate.)

Individual Life Insurance

If you were enrolled in the individual life insurance plan through payroll deductions, you can continue the policy by direct payments to the insurance carrier. Contact Fermilab's Benefits Office for information.

LONG TERM CARE INSURANCE

If you were enrolled in the long term care insurance plan through payroll deductions, you can continue the policy by direct payments to the insurance carrier. Contact Fermilab's Benefits Office for information.

AUTO/HOMEOWNERS INSURANCE

If you were enrolled in the auto/homeowners insurance program through payroll deductions, you can continue the policy by direct payments to the insurance carrier. Contact Fermilab's Benefits Office for information.

ERSIA INFORMATION

Plan Name

Long Term Disability Insurance

Plan Number

504

Employer Identification Number

52-0816670

Plan Sponsor

Universities Research Association, Inc.
(Fermi National Accelerator Laboratory)

Type of Plan

Welfare

Plan Year Ends

The benefit plan records are kept on a calendar year basis. The plan year ends each December 31.

Plan Administrator

Head, Laboratory Services
Fermi National Accelerator Laboratory
P. O. Box 500
Batavia, IL 60510
(630) 840-3396

Plan Fiduciary

Vice President
Universities Research Association, Inc.
Suite 400
1111 19th Street N.W.
Washington, D.C. 20036

Agent of Service of Legal Process

Plan Administrator and/or Plan Fiduciary

Plan Cost

Paid by the employer and employees.

Benefits Provided By

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235

Plan Effective Date

August 1, 1967

Eligibility

All regular full-time employees and full-time scientific term appointments.

Loss of Benefits

You must continue to be a member of the class to which the plan pertains and continue to make any required contributions when you enroll.

Universities Research Association, Inc./ Fermi National Accelerator Laboratory maintains the right through the plan administrator to modify or terminate the plan.

Collective Bargaining Agreements

Benefit information can be found in the following labor agreements.

- Local No. 701, International Association of Machinists and Aerospace Workers (AFL-CIO): Machinist and Welders.
- Local No. I-21, International Association of Fire Fighters (AFL-CIO): Fire Fighters.
- Local No. 701, International Association of Machinists and Aerospace Workers (AFL-CIO): Computer Operators.
- Local No. 701, International Association of Machinists and Aerospace Workers (AFL-CIO): Maintenance Electricians and Mechanics.

Requests For Information and Claim Procedures

Request for information and claims concerning eligibility, participation, contributions, or other aspects of the operation of any plan should be directed to the Plan Administrator.

If a written request or claim is denied, the Administrator

shall, within a reasonable time, provide a written denial to the participant. It will include the specific reasons for denial, the provisions of the plan upon which the denial is based, a description of any material needed to complete the claim (if appropriate) and why it is necessary, and instructions on how to apply for a review of the claim. When the Administrator requires additional time to process a claim because of special circumstances, an extension may be obtained by notifying the participant that a decision on the claim will be delayed, what circumstances have caused the delay and when a decision can be expected. The Administrator will inform the participant of the delay within ninety days of the date the claim was submitted.

A participant may request in writing a review of a denied claim and may review pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the participant a decision upon such request for review of a denied claim within sixty days of receipt of the request. When special circumstances require an extension, the Administrator may obtain such extension by notifying the participant that the decision on the review of the denied claim will be delayed, why and when a decision can be expected. See each plan's section for specifics on how to file a claim.

Rights and Protections

The following statement of ERISA rights is required by federal law and regulation. As a participant in the retirement and welfare plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The Plan Administrator's Office is located at Robert R. Wilson Hall, 15th floor southeast.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator.
3. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Dept. of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Severance Pay Plan

INTRODUCTION

While we hope that the work of Universities Research Association, Inc./Fermi National Accelerator Laboratory ("Fermilab") will continue to expand and flourish, there are times when it may become necessary to reduce staffing. Therefore, Fermilab has created the Universities Research Association, Inc./Fermi National Accelerator Laboratory Severance Pay Plan (the "Plan") to provide employees who terminate employment during a workforce reduction with a temporary source of income.

This booklet is a summary of the terms and conditions of the Plan. It is intended to give you general information concerning the Plan. However, in all instances, the actual Plan document controls. If you have questions or would like to see the actual Plan document, contact the Head of Laboratory Services. The Head of Laboratory Services is the Plan Administrator.

WHAT IS WORKFORCE REDUCTION?

The Plan only applies when a Workforce Reduction is in effect. In order to qualify for benefits, the Workforce Reduction must be approved by the Plan Administrator and the Department of Energy under the Prime Contract. You will be notified if you are subject to a Workforce Reduction.

ELIGIBILITY

In order to be eligible for Severance Benefits, you must meet the following requirements:

1. You must have completed your entry probation period and be a regular full-time employee of Fermilab.
2. You must be notified that you are subject to a Workforce Reduction.

3. You must meet the eligibility requirements for the Workforce Reduction that is currently in effect. These requirements will be provided to you at the time you are notified of the Workforce Reduction.
4. You must be accepted for participation in the Workforce Reduction.
5. You must terminate employment as result the Workforce Reduction within the time period specified for that Workforce Reduction.

Even if you meet these requirements, you will not be eligible to receive benefits if any of the following apply to you.

1 You accept transfer to another facility, subsidiary, or affiliate of Fermilab.
2. You are offered employment at comparable pay and benefits by a successor contractor.
3. You resign.
4. You are terminated for unsatisfactory performance or cause.

BENEFITS

There are two types of benefits that may apply to you. They are: Pay In Lieu Of Notice and Severance Pay. The amount of Severance Pay depends upon whether you are a Weekly or Monthly employee.

Pay In Lieu Of Notice

It is the intent of Fermilab to provide two weeks notice of termination due to a Workforce Reduction. In rare circumstances (such as unforeseen termination of a project) it may not be possible to give you a full two weeks notice before your job is eliminated. Under those circumstances, you will be paid your regular straight time pay for each day that notice was not provided up to the maximum of two weeks.

Severance Pay

In addition to Pay In Lieu Of Notice, you may be entitled to severance pay.

Employees who are non-exempt and paid weekly at the time of termination will be eligible to receive the following benefits:

Non-Exempt (Weekly) Employees

Years of Service	Severance Pay
Less than 1 year	2 weeks
1 year to 5 years	3 weeks
5 years to 10 years	5 weeks
10 years to 15 years	7 weeks
15 years to 20 years	9 weeks
20 years to 25 years	11 weeks
25 years to 30 years	13 weeks

Employees who are exempt and paid monthly at the time of termination will be eligible to receive the following benefits:

Exempt (Monthly) Employees

Years of Service	Severance Pay
Less than 1 year	1 month
1 year to 5 years	2 months
5 years to 10 years	3 months
10 years to 15 years	4 months
15 years to 20 years	5 months
20 years to 30 years	6 months
30 years to 35 years	7 months

Severance pay is based on your regular base pay excluding overtime, shift differentials and bonuses. In no event is an Employee eligible for benefits both as a Weekly and Monthly Employee.

Deductions From Benefits

Severance Benefits are subject to all applicable federal and state deductions and withholding.

HOW ARE BENEFITS PAID?

Severance is paid in a single lump sum payment.

REEMPLOYMENT

Upon receipt of a lump sum, you will no longer have a right to reemployment with Fermilab. In the event that you are later reemployed, you may be required to refund any Severance Benefits received.

OTHER BENEFITS

Along with your notice of Workforce Reduction, you will receive a statement of any other benefit options that may be available to you. The acceptance of Severance Benefits will not effect any right that you may have under retirement or other plans of Fermilab, which are controlled by the terms of those plans.

CLAIM PROCEDURES

Any Employee who believes that he is entitled to a benefit under the Plan in an amount greater than he has received may file a claim for such benefit by writing to the Plan Administrator.

Every claim which is properly filed shall be answered in writing within ninety (90) days (or one hundred eighty (180) days if special circumstances require an extension of time for processing the claim) of receipt stating whether the claim is granted or denied. If the claim is denied, the claimant shall be provided specific reasons for denial; specific reference to the pertinent Plan provisions on which the denial is based; a description of any information necessary for the claimant to perfect a claim including an explanation of why such information is necessary; and an explanation of the Plan's claim appeal procedure including steps to be taken to submit the claim for review.

Within sixty (60) days after notice that a claim is denied, the claimant may file a written appeal which shall include any comments, statements or documents the claimant may wish to provide. Notice of the decision on appeal shall be sent to the claimant within sixty (60) days of its receipt (or one hundred twenty (120) days if special circumstances require an extension of time for processing the appeal). In the event the claim is denied upon appeal, the notice shall set forth the reasons for denial written in a manner calculated to be understood by the claimant and specific reference to the pertinent provisions of the Plan on which the denial is based. Any reasonable request from a claimant for documents or information relevant to his claim prior to his filing an appeal shall also be allowed.

If notice of the denial of the claim or appeal is not furnished in the time limits set forth above, the claim or appeal shall be deemed denied.

MISCELLANEOUS PROVISIONS

No Guarantee Of Employment

Nothing contained in the Plan shall be construed as an agreement of employment, or as giving or conferring on any Employee the right to continued employment, or as a limitation on the right of an Fermilab to terminate the employment of an Employee, with or without cause.

Funding

Benefits are paid out of the general assets of Fermilab pursuant to the Prime Contract. Fermilab is not required to fund or otherwise provide for the payment of benefits in any manner.

Amendment and Termination

Fermilab expects to continue the Plan indefinitely. However, it reserves the right to amend or terminate the Plan at any time, prospectively or retroactively, and for any reason. If the Plan is amended or terminated, Employees may not receive benefits as described in this Plan, may be entitled to receive different benefits, or benefits under different conditions. It is possible that Employees will lose all benefit coverage. This may happen at any time, if Fermilab decides to terminate the Plan or any coverage under the Plan. In no event will anyone become entitled to any vested rights under this Plan.

GENERAL PROVISIONS

Statement of ERISA Rights

As a participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

a. Examine, without charge, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions. The documents may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.

b. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for Plan participants, ERISA imposes duties upon the people, called "fiduciaries", who are responsible for the operation of the employee benefit Plan. They have a duty to operate the Plan prudently and in the interest of Plan participants and beneficiaries. Your employer may not fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, you may file suit in a Federal court if you request materials from the Plan and do not receive them within 30 days. The court may require the Plan administrator to provide the materials and pay you up to $110.00 a day until you receive them (unless the materials were not sent because of reasons beyond the administrator's control). If your claim for benefits is denied in whole or in part, or ignored, you may file suit in a state or federal court. If Plan fiduciaries misuse the Plan's money, or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If you are successful, the court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay; for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

INFORMATION ABOUT THE PLAN

Name of the Plan

Universities Research Association, Inc.
Fermi National Accelerator Laboratory
Severance Pay Plan

Plan Number

516

Plan Sponsor

Universities Research Association, Inc.
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, Illinois 60510

Sponsor Employer I.D.

52-0816670

Plan Administrator

Head of Laboratory Services
Fermilab
P.O. Box 500
Batavia, Illinois 60510 (630) 840-3396

Agent for Service of Legal Process

Plan Administrator

Pay Plan

Calendar Year

Supplemental Retirement Plan

INTRODUCTION

Congress created for employees of education and not-for-profit organizations a section of the tax code which provides for the creation of tax sheltered annuities and custodial accounts. The purpose is to build additional retirement income on a tax deferred basis as long as the employee works. The Board of Trustees of Universities Research Association, Inc. (URA) established the Fermi National Accelerator Laboratory Tax Sheltered Annuity Plan as of July 1, 1975.

Although URA makes generous contributions into the Fermilab's basic pension plan and Social Security, employees should consider making voluntary contributions to this supplemental plan in order to provide for their retirement. Fermilab's basic pension plan and Social Security may not be enough. The voluntary supplemental plan gives employees the opportunity to save for retirement on a tax sheltered basis.

A tax sheltered plan means that you are permitted to direct dollars into investments before those dollars are taxed for federal and state income taxes. This is called investing on a tax deferred basis. Tax deferral into this plan does not reduce your Social Security contributions or benefits. After deciding upon the amount that you want to contribute (up to the maximum permitted by law), you enter into a salary reduction agreement with URA (Fermilab) specifying the percentage of salary or fixed dollar amount that you want to contribute. The contribution is invested according to the investment options you select. When the money is eventually withdrawn, you pay taxes at the tax rate applicable to you at the time.

URA offers five fund sponsors or funding vehicles from which to choose. They are Dreyfus Funds, Fidelity Funds, TIAA-CREF Retirement Annuities, TIAA-CREF Supplemental Retirement Annuities, and T. Rowe Price Funds. Other fund sponsors may be approved and added from time to time.

The fund sponsors offer many options. The options increase flexibility and choice, and they also may introduce considerable risk. Some investments may turn out to be unprofitable. Before investing in a fund or funds, employees should review the fund's prospectus, and if uncertain, employees are urged to seek outside professional advice. This is an individual choice, and employees are urged to consider this matter carefully.

URA makes no recommendations and no guarantees. Some funds may turn out to be unprofitable, and URA accepts no responsibility for this.

Who Is Eligible

All paid employees of Universities Research Association, Inc. Fermi National Accelerator Laboratory. (Consultants and contract employees are not considered employees of URA/Fermilab.)

Enrollment

You are eligible to join the plan as of your first day of employment. You must complete a salary reduction agreement, and if you do not have a supplemental retirement account (SRA) with a fund sponsor, you must complete a sponsor application. Submit both forms to Fermilab's Benefits Office.

Salary Reduction Agreement

It is an agreement between you and URA (Fermilab), whereby you agree to reduce your salary by the amount you want to contribute to a supplemental retirement account (SRA). The signed agreement authorizes Fermilab to forward your contributions to a fund sponsor.

Tax-Deferred Contributions

The amount that you are eligible to tax-defer is subject to the limitations of Sections 403(b), 402(g) and 415 of the Internal Revenue Code. In calendar year 2002, employees may contribute the lessor of 100% of pay or $11,000. The limit will increase to $12,000 in 2003, $13,000 in 2004, $14,000 in 2005 and $15,000 in 2006. Beginning in 2007, the limit will be indexed in $500 increments. Employees age 50 and older may make elective deferred contributions beyond the $11,000 limit in 2002. These employees will be able to contribute an additional $1,000 in 2002, $2,000 in 2003, $3,000 in 2004, $4,000 in 2005 and $5,000 in 2006. Beginning in 2007, catchup contributions will be indexed in $500 increments.

Excess Contribution

Fermilab's payroll system is programmed to keep employee's contributions within legal limits. In the event that an employee has contributions that exceed the dollar limits in effect under Section 402(g) of the Code at the beginning of the tax year, the employee may designate

the contributions made during a taxable year as excess contributions by notifying Fermilab's Benefits Office on or before March 1 of the following year of the amount of the excess. The excess contribution will be distributed to the employee no later than April 15 of the calendar year following the taxable year in which the excess contribution was made.

Changing Contributions

You can change the amount of your contribution by entering a new salary reduction agreement. You can only do this once per month. You may cancel a salary reduction agreement at any time.

Termination of Participation

An employee will continue to participate in the plan until he or she terminates employment, URA (Fermilab) terminates the plan or you terminate your salary reduction agreement, whichever occurs first.

Allocation of Contributions

You may allocate contributions among more than one sponsor provided you meet each sponsor's minimum investment requirement, if any. You may allocate contributions among sponsors in any whole number percentages that in total equal 100% of the contribution.

Transfer of Contributions

You may make transfers between a sponsor's family of funds subject to their transfer rules and requirements. You may call the fund sponsor to execute a transfer within a family of funds. You may also transfer between fund sponsors, subject to any restrictions imposed by the sponsors. A transfer between sponsors requires completed forms available from the fund sponsors.

Allocation Changes

You may change your allocations as often as the fund sponsors allow.

Fees

No expense charges are deducted from your contributions. The costs associated with investment in a particular fund are fees for management and operating expenses charged against the total fund. Operating fees are deducted from the fund's assets and are subject to change without notice. The fees can range from .25 of 1% to 1.50%. In addition, participant's accounts may be charged an administrative fee. Contact the custodian for information.

There are a few employees investing in Van Guard funds. For information and an application, you may contact those companies directly. Fermilab's Benefits Office does not maintain that information.

When the plan was established all of the sponsor's options were "no load" funds, which means there is no charge for buying and selling shares. Since the inception of the plan, some sponsors have added funds, which may have "loads." Check the fund's prospectus before investing.

Information on Fund Sponsors

Informational materials, applications and prospectuses are available from Fermilab's Benefits Office and the Fund Sponsors.

Withdrawals While Employed

Withdrawals are subject to IRS regulations and the funding vehicle's restrictions. The only withdrawals allowed during active service are amounts you accrued in TIAA-CREF Supplemental Retirement Annuities prior to December 31, 1988. Otherwise, you must be age 59½ or qualify for a withdrawal under IRS hardship withdrawal rules. No withdrawals are allowed from TIAA-CREF Retirement Annuities during active service.

Accumulations with the other fund sponsors are subject to the same age 59½ and hardship withdrawal rules.

Withdrawal Options at Termination of Employment

You are entitled to receive benefits under any of the options provided by the funding vehicles.

Accumulations in TIAA-CREF Supplemental Retirement Annuities (SRA) may be distributed as: a single sum pay out, periodic pay outs, fixed period annuities and life annuities.

Contributions made to TIAA-CREF Retirement Annuities (RA) may be distributed as: a single sum pay out provided you are eligible (See "Repurchase Option"). Otherwise, contributions you made may be distributed as: TIAA-CREF life annuities, TIAA 10 year pay out, TIAA interest only pay out, CREF single sum pay out, CREF Systematic withdrawals and CREF fixed annuities. Any contributions made by URA (Fermilab) into TIAA-CREF Retirement Annuities (RA) on your behalf under the plan's old provision may be distributed as a CREF single sum pay

out if you meet the service requirements set forth in the qualified plan, Retirement Plan for Employees of Universities Research Association, Fermi National Accelerator Laboratory established on March 1, 1989.

For detailed information about the TIAA-CREF pay out options and benefit illustrations, you may contact TIAA-CREF.

Accumulations with the other Fund Sponsors may be distributed as: a single sum pay out, periodic pay outs or you may use accumulations to purchase annuities. For detailed information about pay out options, you may contact the Fund Sponsors.

Additional Options at Termination of Employment

You may leave accumulations in the funding vehicles and continue to participate in the earnings and losses of the funding vehicles. However, under federal regulations you are required on the April 1st following your seventy and one half (70½) birthday, or on the April 1st following the calendar year in which you retire, whichever is later, to start receiving a minimum distribution from your accumulations.

Repurchase Option

If you have funds in TIAA-CREF Retirement Annuities, you may receive your accumulation in a single sum when you terminate your employment with URA: if the TIAA Retirement Annuity accumulation is less than $2,000, the total TIAA-CREF Retirement Annuity accumulation is less than $4,000, and you do not have a TIAA Transfer Payout Annuity (TPA) in force.

Before exercising the repurchase option or any distribution option, you may want to consult with your tax advisor regarding tax consequences.

Hardship Withdrawal

While employed by URA you may make withdrawals from your TIAA-CREF Supplemental Retirement Annuities or mutual fund custodial accounts if withdrawals qualify under IRS hardship withdrawal rules.

Hardship withdrawals are allowed only if the participant has an immediate and heavy financial need, and no other resources reasonably available to meet the need.

Withdrawals will be considered to be made on account of immediate and heavy financial need of the employee, including those for expenses which are foreseeable and voluntary, if they are for: (a) medical expenses incurred by the participant, spouse or dependents; (b) purchase (excluding mortgage payments) of a principal residence of the participant; (c) payment of tuition and related educational fees for the next 12 months of post-secondary education for the participant, spouse or dependents; and (d) payments to prevent eviction from or foreclosure on the principal residence of the participant.

To qualify for a financial hardship, the employee will be required to provide appropriate documentation that a need exists that cannot be relieved by: stopping contributions to the plan, reimbursement or compensation by insurance, distributions or nontaxable loans from benefit plans maintained by any employer, borrowing from commercial sources on reasonable commercial terms, and reasonable liquidation of assets.

The hardship distribution cannot exceed the need, is disbursed from principal not interest, and is subject to income tax and possible tax penalty. Employee contributions to this plan are suspended for one year, and at the end of the one year suspension, contributions may be started upon completion of a new salary reduction agreement.

Hardship withdrawal restrictions *do not* apply to pre-1989 funds in TIAA-CREF Supplemental Annuities. You can receive a cash distribution of these accumulations at any time, subject to possible tax penalties.

Taxes on Distributions

A distribution from this plan will be taxed as you receive it. Generally, income from this plan is subject to ordinary income tax and possibly to an excise tax if a distribution exceeds a certain amount. Distributions received before age 59½ are also subject to a 10% additional tax unless one of several exceptions applies. However, your distribution may also be eligible for the direct rollover option described below.

Effective January 1, 1993, the plan permits you to directly rollover any distribution from the plan to any eligible retirement plan, if that eligible retirement plan permits. An eligible retirement plan is generally another 403(b) plan or an individual retirement arrangement. If you elect

to take a distribution from the plan that is subject to the direct rollover option and fail to exercise that option, 20% of the distribution will be withheld from you for the purpose of paying income tax consequences that may arise.

Before you elect a distribution from the plan, you should check with your professional tax advisor for more information on the tax consequences of receiving a distribution.

Loans

Participants with funds in TIAA-CREF Supplemental Retirement Annuities may take a loan from those annuities. For additional information you may contact TIAA-CREF. There are no loan provisions in the other funding vehicles.

Death Before Benefits Start

The full current value of your accounts is payable as a death benefit to your beneficiary. A single sum payout is available as well as other payout options offered by the funds' sponsors. A single sum must be paid if you are not married and your beneficiary is your estate, a corporation, association or other entity not a natural person. Current federal tax law puts limitations on when and how beneficiaries receive their death benefits. Your beneficiary may want to seek advise from a professional tax consultant at the time he or she applies for benefits.

Spousal Rights

Benefits may be paid to married participants under the spousal entitlement provisions described below. The married participant and spouse may waive the spousal entitlement to receive benefits, but only if a written waiver of the benefit, signed by the employee and the spouse is filed with the fund sponsor in a form acceptable to the fund sponsor.

Pre-Retirement Spousal Entitlement:

If the participant dies before the start of retirement benefit payments, and a waiver of spousal entitlement to receive benefits has not been filed, the surviving spouse shall receive a benefit that is at least 50% of the balance of the participant's accumulation account, payable under one of the payment methods offered by the fund sponsor.

The period during which the participant and his or her spouse may elect to waive the pre-retirement survivor benefit begins on the first day of the plan year in which the participant attains age 35 and continues until the earlier of the participant's death or the date the participant retires. If the participant dies before attaining age 35, at least 50% of the value of any accumulation account is payable automatically to the surviving spouse in a single sum or under one of the payment methods offered by the fund sponsor.

Post-Retirement Spousal Entitlement:

If the participant dies following retirement, the surviving spouse will receive retirement benefits of at least 50% of the benefits payable during the joint lives of the participant and his or her spouse.

A waiver of this post-retirement survivor benefit (joint and survivor annuity) may be made by the participant and his or her spouse only during the 90 days prior to commencement of benefit payments. The waiver may also be revoked by the participant during the same period. It may not, however, be revoked after retirement benefits begin.

Must Start Benefits

A participant must normally start to receive benefits no later than April 1 of the year following the calendar year in which the participant attains age 70½, or April 1 following the calendar year in which the participant retires, whichever is later. If the participant dies before the distribution of benefits has begun, the entire interest of the participant must normally be distributed within 5 years after the death of the participant. Under a special rule, death benefits may be payable over the life or life expectancy of a designated beneficiary provided the distribution of benefits begins not later than 1 year from the date of the participant's death. If the designated beneficiary is the spouse of the deceased participant, the commencement of benefits may be deferred until the participant would have attained age 70-1/2 had he or she continued to live.

The payment of benefits in accordance with the above rules is extremely important. Federal tax law imposes an excise tax on the differences between the amount of benefits required by law to be distributed and the amount actually distributed. Before you elect a distribution from the plan, you should check with your professional tax advisor for more information on the tax consequences of receiving a distribution.

Plan Changes

Universities Research Association reserves the right to amend, terminate or discontinue any further contributions under the plan. If the plan is terminated or if contributions are discontinued, employees will be notified and any salary reduction will become void with respect to salary amounts yet to be earned.

Transfer of Benefits

You are not permitted to sell, trade or assign your benefits under the plan. However, if a court order in a divorce suit satisfies the Internal Revenue Code requirements and so directs, the plan administrator may be required to pay all or a part of your benefits to a person other than you or your beneficiary.

Claim Procedures

Any claims must be in writing and initially directed to the fund sponsor. The employee must exhaust all administrative remedies with the fund sponsor. If a written claim with the fund sponsor is denied after the exhaustion of the fund sponsor's administrative remedies, the employee may make a written claim with the plan administrator. Upon receipt of an employee's written claim, the plan administrator shall either approve or deny the claim for benefits. If the claim for benefits is denied, the plan administrator shall, within a reasonable time, provide a written denial to the employee. The denial will include the specific reasons for denial, the provisions of the plan upon which the denial is based, a description of any material needed to complete the claims (if appropriate) and why it is necessary, and instructions on how to apply for a review of the claim. When the plan administrator requires additional time to process a claim because of special circumstances, an extension may be obtained by notifying the employee that a decision on the claim will be delayed, what circumstances have caused the delay, and when a decision can be expected. The plan administrator will inform the employee of the delay within 90 days of the date the claim was submitted.

An employee may request in writing a review of a denied claim and may review pertinent documents and submit issues and comments in writing to the plan administrator. The plan administrator shall provide in writing to the employee a decision upon such request for review of a denied claim, within 60 days of receipt of the request. When special circumstances require an extension, the plan administrator may obtain such extension by notifying the employee that the decision on the review of the denied claim will be delayed, and why and when a decision can be expected.

Your Right's Under The Law

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). You are entitled to:

1. Examine, without charge, a the plan administrator's office all documents, including insurance contracts, and copies of all documents field by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.

2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a summary of the plan's financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefits or exercising your rights under ERISA. If your claim for benefits is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored

in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.

No Guarantees

Benefits are not guaranteed by the Pension Benefit Guaranty. PBGC requirements do not apply to this plan. Further, benefits are not guaranteed by Universities Research Association.

Under no circumstances does the maintenance of the plan constitute a contract of employment. In addition, provisions of this Summary Plan Description do not constitute a contractual agreement with Universities Research Association.

ERISA INFORMATION

Plan Sponsor

Universities Research Association, Inc. (URA, Inc.)

Agent for Service of Legal Process

Plan Administrator or Fund Sponsor

Plan Name

Fermi National Accelerator Laboratory Tax-Sheltered Annuity Plan

Plan Number

001

Employer Identification Number

52-0816670

Plan Year

January 1 to December 31

Plan Administrator

Head, Laboratory Services
Fermi National Accelerator Laboratory
P.O. Box 500
Batavia, IL 60510
(630) 840-3396

Fiduciary

Universities Research Association, Inc.
111 19th St., NW, Suite 400
Washington, D.C. 20036

Funding Vehicles/Fund Sponsors

Dreyfus Retirement Services
144 Glenn Curtiss Boulevard
Uniondale, NY 11556-0144
(800) 221-3763

Fidelity Investments
Institutional Services
82 Devonshire St.
Boston, MA 02109
(800) 343-0860

Teacher Insurance & Annuity Association (TIAA)
College Retirement Equities Fund (CREF)
730 Third Ave.
New York, NY 10017
(800) 842-2733

T. Rowe Price Funds
P.O. Box 2357
Boston, MA 02107
(800) 638-5600

Effective Date of Plan

July 1, 1975

FERMI NATIONAL ACCELERATOR LABORATORY
A DEPARTMENT OF ENERGY NATIONAL LABORATORY